DOCUMENT RESUME

ED 210 567 CG 015 592

AUTHOR	Brown, Vivian B.; And Others
TITLE	Consensus and Controversy in Sexual Assault Prevention and Intervention: A Delphi Study.
INSTITUTION	Southern California Rape Prevention Study Center, Culver City, Calif.
SPONS AGENCY	National Inst. of Mental Health (DHHS), Rockville, Md. National Center for the Control and Prevention of Rape.
PUB DATE	81
GRANT	NIMH-I-R18-MH-33068
NOTE	155p.
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Attitude Change; Behavior Change; *Crisis Intervention; *Emotional Adjustment; Helping Relationship; Individual Needs; *Needs Assessment; *Prevention; *Rape; Sexuality; Standards; *Victims of Crime; Violence

ABSTRACT

Sexual assault literature reveals inconsistencies regarding important issues in establishing prevention and intervention standards. The Delphi inquiry technique was used to examine concepts and criteria for practice and to explore assumptions and value dilemmas in sexual assault prevention and treatment. Expert judgments were made by 51 nationally-based participants in the sexual assault field. Questions about intervention with sexual assault victims revealed that assisting victims in coping with emotional and physical trauma and minimizing risk to potential victims were the respondents' highest priority goals. In terms of intervention with assailants, participants emphasized behavioral change outcomes; the use of constructive behavioral alternative in place of coercive sexuality was given highest importance for assailants and potential assailants. In the area of primary prevention, participants ascribed high priority to changing social institutions and individual attitudes and behaviors to alleviate conditions that permitted sexual assault. Respondents expressed uncertainty as to the best way to accomplish primary prevention. Participants found legal definitions inadequate from conceptual and practical standpoints; they preferred the concept "sexual assault" to "rape" and recommended defining that concept as simply "any forced sexual activity." Results suggest several implications for intervention, prevention, treatment, research, and policy. (NRB)

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CONSENSUS AND CONTROVERSY IN SEXUAL ASSAULT PREVENTION AND INTERVENTION: A DELPHI STUDY

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This monograph was developed under a grant from the National Center for the Prevention and Control of Rape, NIMH, grant no. 1R18MH33068

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ACKNOWLEDGEMENTS

In preparing this report, we asked many individuals who are concerned with alleviating the damaging effects of sexual assault--rape crisis center workers, mental health providers, health professionals, social service personnel, criminal justice personnel, and researchers--to respond to our Delphi questionnaires. We are indebted to all the Delphi participants for sharing their knowledge, experience, and opinions with us. We hope that we have respected their varied points of view while communicating their common messages.

The process of sorting out the most critical issues and strategies to be addressed in the Delphi questionnaire was accomplished with the constructive review and assistance of our staff and consultants. Special thanks are owed to the group of people who pretested the questionnaire sections. Our thanks go also to Connie Destito, M.S.W. and Susan Vivell, Ph.D. for their early contributions to development of the research. The analyses of data for the Delphi Study and its reporting in this monograph involved a number of staff from the SCRPSC and DHCMHC. These staff members were:

Bill Dombrowski, M.A., Research Associate, who took a major role in carrying out statistical procedures;

Grace Hardgrove, M.S.W., Training Coordinator, who received and commented on sections of this monograph;

Rose Gross, Project Secretary, who helped to keep us organized, to meet all the Project deadlines, and to get us into print;

Lori Greenfield, Aline Gardner, and Lorenza Loza who assisted us in all the secretarial activities. A special thanks to Lori for the design of the monograph cover.

It is with pleasure that we thank such a willing, dedicated and competent group for all their services. We are also pleased at the opportunity to acknowledge the continuing support and assistance of Gerald F. Jacobson, M.D., Executive Director of Didi Hirsch Community Mental Health Center/LAPS.

Finally, we wish to acknowledge with gratitute the strong interest and support we have received from the National Center for Prevention and Control of Rape. Special thanks to Gloria Levin, Ph.D. who contributed much to the early planning processes for this study.

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We also extend our appreciation to the Didi Hirsch Community Mental Health Center/LAPS for acting as the administrative host of the project. The scientific content of this project and of this publication, however, are the sole responsibility of the staff of the Southern California Rape Prevention Study Center and do not necessarily reflect the opinions of the Didi Hirsch Community Mental Health Center/LAPS.

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EXECUTIVE SUMMARY

This monograph describes the results of a national study conducted to examine concepts and criteria for practice and to explore assumptions and value dilemmas in sexual assault prevention and treatment. The research was carried out by the Southern California Rape Prevention Study Center, a Regional Research and Demonstration Center funded by the NCPCR. This investigation is part of our Center's activities which include not only research but also implementation and evaluation of training, consultation and dissemination programs concerned with sexual assault prevention and treatment. We hope that this monograph will prove helpful to practitioners and researchers working in the sexual assault area from a variety of perspectives--mental health, rape crisis, medical treatment, criminal justice, law enforcement, and social service. Its purpose is to suggest priorities and highlight areas of consensus, controversy and uncertainty in the state-of-the-art practice of sexual assault prevention and intervention.

A review of current sexual assault literature reveals conflict and inconsistency regarding issues of considerable importance in establishing appropriate standards of practice. In fact, the state-of-the-art in this field has not been able to keep pace with rapidly growing prevention and intervention needs. To help bridge the gap between needs and resources, we initiated a systematic investigation of expert judgment using the Delphi inquiry technique. Briefly, Delphi procedures differ from other survey procedures by giving each participant multiple opportunities to answer the same set of questions; for each repeated round of inquiry, participants are given summaries of previous-round responses to consider in formulating their judgment. For the present study, three rounds of inquiry were employed. The 51 nationally-based participants are individuals recognized for their contributions to the sexual assault field and represent a range of practitioner and research orientations. Their responses to objective questionnaire items were analyzed to provide information about extent of agreement, disagreement and uncertainty among knowledgeable workers. Judgments obtained from this group are regarded as valid guides for future practice, policy and research.

Results of the research are discussed in an order that parallels the order of the questionnaire included as Appendix A. The four sets of results (addressing victim intervention, assailant intervention, primary prevention, and sexual assault concepts respectively) are similarly organized in the text, each starting with descriptive statistics and ending with a brief summary. Technical material has been minimized or omitted in the interest of brevity (the Study Center staff, however, welcomes requests for additional information).

Questions about intervention with victims of sexual assault yielded highly consensual judgments from participants (summarized on pp. 38-39). Assisting assault victims in coping with the emotional and physical trauma, as well as minimizing risk to potential victims, were endorsed as intervention goals of highest priority. Four kinds of provider characteristics emerged as requisite in this area. Among them, generic interview skills (e.g., conducting interviews in a nonjudgmental, ethical and responsible manner) were most consistently valued. Other provider factors were the ability to apply psychotherapeutic procedures to individualized treatment design, to acquire and communicate relevant resource information, and to identify appropriate intervention targets.

Questions about intervention with assailants yielded less consensus and more controversy (as summarized on p.48). In this area participants strongly emphasized outcomes related to behavioral rather than intrapersonal change. Among them, the use of constructive behavioral alternative in place of coercive sexuality was given highest importance for both assailants and potential assailants. This finding is consistent with participants' beliefs that sexual assault is primarily aggressive or violent, rather than sexual, in motivation. Requisite provider characteristics for assailant intervention, like victim intervention, included generic interview skills and more specific psychotherapeutic knowledge. A third kind of provider requisite involved capability in carrying out activities related to holding assailants legally accountable, reflecting the view that intervention with assailants appropriately comprises both treatment and enforcement.

Issues in the area of primary prevention exhibited great certainty about ends and uncertainty about means (see summary, p. 61). Participants consensually ascribed high priority to changing social institutions and to changing individual attitudes and behaviors, in order to alleviate conditions that support or permit sexual assault. Families, educational settings, and public media were singled out as the socialization agents that should be targeted first for institutional change. Recommendations for attitude change emphasized valuing equality and self-determination in human interactions and intolerance of any victimization. Suggested behavior changes included greater independence and self-reliance for women, and more cooperative and constructive behavior for men. However, while participants believed primary prevention was both desirable and possible, they were very unsure of how best to accomplish it. Reduction of the incidence of sexual assault turns on finding out what kinds of strategies will most effectively induce individual-and system-level change.

The final research area concerned terms and definitions for central concepts in the sexual assault field. At this broad theoretical level, participants' judgments manifested strongest accord (see summary, p. 66). The major conclusion to be drawn from these data is that current legal definitions are inadequate from both a conceptual and practical standpoint. Respondents prefer the designation "sexual assault" instead of "rape," perhaps because the latter term has been so narrowly construed. Concommitantly they recommended defining that concept clearly and simply as any "forced sexual activity."

These results provide the basis for drawing a variety of conclusions, organized in terms of implications for intervention, prevention, training, research and policy (Chapter 4). Implications for intervention are given a great deal of attention because intervention issues were so throughly assessed in the questionnaire and because participant judgments in this area are readily translatable into recommendations for practice.

Most strongly endorsed outcomes associated with victim intervention have to do with providing assistance in coping with the emotional and physical trauma of sexual assault (e.g., restoring the victim's sense of self worth, insuring that the victim feels believed and understood); it is recommended that such objectives become a regular part of treatment plans and protocols. The design of intervention should be guided by individualized needs and abilities of victims, with an emphasis on what is available in conscious awareness. Participants' judgments, taken as a whole, lend support to the viability of a crisis intervention model for treatment of sexual assault victims. Further investigation is needed to resolve questions about the role of generic features of trauma and unconscious processes in designing victim intervention procedures. Additional research is especially needed for determining most effective treatment strategies with juvenile victims of sexual assault, and for exploring alternative protective arrangements. In the area of assailant intervention a contrasting treatment orientation is recommended that focuses on attitudinal and behavioral changes rather than intrapersonal objectives; most desired outcomes in these domains are more egalitarian attitudes toward women and alternative ways of handling anger.

Analysis of responses to questions about primary prevention indicated a need to generate and test a range of system-and individual-level change strategies, since effective means for eliminating conditions conducive to sexual assault are difficult to specify. However, participant judgments make clear that those conditions are reinforced by a society that permits violence and aggression; consequently, primary prevention efforts aimed at sexual assault should be linked with other preventive programs directed at reduction of destructive interpersonal behavior.

Major institutional targets of primary prevention should be families, educational agencies, and public media, while individual-level programs ought first to target adolescents (especially, early adolescents). Attempts at primary prevention of sexual assault would do well to make use of community education models.

With respect to training of practitioners, respondents' judgments were consistent whether questions concerned treatment of victims or assailants. Factorial analyses of requisite provider characteristics led to the conclusion that generic interview skills are most important in training; next in importance are specific intervention skills; and third, an effective and relevant knowledge base. Implications for development of practitioner programs consequently are quite straightforward. Implications for future research are also generated in a rather straightforward manner from the data. Where participant judgments consensually award a set of objectives or procedures very high priority, their implementation in terms of demonstration or evaluation research is recommended. Where participant judgments do not achieve consensus because of significant differences in viewpoint between subgroups, research directed toward conflict clarification and resolution is suggested. Last, where participant judgments do not converge toward conseusus because of general uncertainty, knowledge-gathering research is warranted.

Policy implications generated from this research are discussed last. Among them, the most immediate and also the most readily implemented concern change in the legal definition of major sexual assault terms ("rape" and "incest"). Participants unequivocally found current legal definitions inadequate; they endorsed broader concepts that deemphasize the type of relationship or contact between victim and assailant and rely directly on the construct of coercive sexual behavior. Another set of policy recommendations concern the development of cost effective and collaborative intervention programs whose features incorporate goals, outcomes and methods judged most viable by participants. Perhaps of greatest long-term importance are implications for primary prevention. In view of the high priority placed on primary prevention goals together with uncertainty about how they are best implemented. the need to produce a sophisticated technology for primary prevention is clear. Urgently recommended are action research and policy development directed toward social change and aimed specifically at the reduction or elimination of nonconstructive methods for dealing with anger of social power discrepancies, and of coercion or oppression.

CHAPTER 1: RATIONALE

Rationale for a Regional Research and Demonstration Center

The planning for a regional research and demonstration center began early in 1978. At that time, an increasing volume of rape-related research and materials were being developed and tested throughout the country under the sponsorship of the National Center for the Prevention and Control of Rape. Because of this increasing volume of research work, an increasing number of rape crisis programs, and an increasing volume of training and prevention materials, it was believed that the creation of regionally-based research and demonstration centers was timely and necessary. The potential value of person-to-person communication and of actual demonstration of innovative ideas as mechanisms for facilitating change seemed well established. The research and demonstration centers could serve in the roles of integrator or synthesizer of large numbers of studies, translator of technical research reports and already existing solutions to problems, and knowledge linker between researcher and practitioner.

It was further assumed that the entire sexual assault treatment and prevention system could be strengthened if service providers (practitioners) could be linked more closely to the resource system; this would narrow the gap between new ideas and methods and the actual practice of service deliverers. There was considerable evidence in the knowledge-utilization-dissemination literature that suggested that innovations spread most effectively when their dissemination was facilitated by a person or group functioning as a linking agent. As well as bringing new materials and innovations to the attention of local practitioners and researchers, the linking agent is also in a position to provide on-site training and consultation designed to meet the unique needs of a particular region. Dissemination, coupled with training and consultation, would allow an economy of effort for the developers of new services and an updating of information and skills for existing services. Common procedures need not be reinvented at every local agency, and dissemination would also reduce the haphazardness and lack of systematic development of contributions to the knowledge base. The development and utilization of a systematic knowledge base for all types of organizations would also allow for the emergence of concepts, standards and criteria for practice.

Given the high degree of concentration of resources within the research network on the one hand, and the extreme dispersion of the user system on the other, it was felt that regional linking institutions could best supply the need for face-to-face communications between practitioner and research systems on a long-term basis and facilitate short-term collaborative efforts. The regional research and demonstration center would then also provide for a mechanism for feedback to the research system, informing researchers about how research and demonstration products are faring in applied settings, and for a mechanism of "feed forward," informing researchers about practitioner problems for which there are no current solutions and thereby help to initiate new research.

With these considerations in mind, the Southern California Rape Prevention Study Center was designed to serve four major functions:

1. Its first function is to formulate concepts, criteria, and standards for the practice and teaching of rape prevention and treatment. This can be done by analyzing the services provided and the scope of existing practices in the field; by reviewing relevant literature in the field, including research, clinical reports, prevention materials and content of training curricula; by conducting a study to ascertain areas of consensus and controversy among national and regional experts in the field.
2. The second major function is to put into operation a training program designed to meet the needs of trainees in, or near, Southern California region. While the primary emphasis is on training in the area of rape prevention and treatment, the training program must include the areas of general crisis intervention, program management, and program evaluation.
3. The third major function is to provide consultation, teaching materials, and practical guidelines to any existing program in the Southern California region. While the training function takes priority, it is important to provide agencies and their staff members with ongoing consultation; it is through the consultation process that programs will be able to continue their training within their own unique program structure, update their skills, and evaluate their own effectiveness.
4. The fourth major function is to disseminate information about rape prevention and treatment. This includes serving as a clearinghouse and testing site for materials developed by the National Center and other local centers. On a broader level, the project is attempting to learn more about effective information dissemination processes.

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Project Components. Four project components were established in order to accomplish the Research and Demonstration Center objectives. These consisted of a research and evaluation component, a training component, a consultation component and a dissemination component. While each component can function as a separate unit, interaction among the four components is emphasized. The conscious interfacing of component activities allows for the development of a cumulative knowledge base that has implications for each of the Center components.

Work within the research and evaluation component is, by its nature, highly interactive with the other components. This is so for two reasons. First, within all components there are formative and summative evaluations and complete documentation of all Research and Demonstration Center activities. Second, the work of this component in the formulation of standards for practice and training has a direct impact on the training and consultation components. Critical to the operation and success of the Research and Demonstration Center in its linking role between the National Center and local practitioners and between researchers and practitioners is a series of research and evaluation efforts that have implications for the Research and Demonstration Center's entire scope of work. The primary component functions are:

1. needs assessment and systems analysis in the Southern California area;
2. analysis of resource materials and literature;
3. conducting a study to ascertain areas of consensus and controversy among national and regional experts in the field;
4. measurement of effectiveness of all other program components - training, consultation and dissemination;
5. conducting additional research studies.

In addition to being responsive to the findings of the research and evaluation component, the training and consultation components must continually provide information about specific needs, constraints, and local practices in the course of providing service to local practitioners. This input from the field is extremely important for standard-setting and for the process of developing and disseminating materials. Training and consultation activities also need to take into account the broad range of practitioners providing rape prevention and treatment services, including personnel in rape crisis centers, community mental health centers, hospitals emergency rooms, and police units.

The dissemination component is an integral and unique part of the R & D Center. In addition to making written and audio-visual materials available upon request, these materials are also provided in conjunction with training and consultation to agencies, thus helping to further raise their standards of service. The center is also particularly committed to developing and evaluating innovative techniques for information dissemination. Establishing temporary and long-term mechanisms for facilitating communication among practitioners and researchers holding different value orientations and using different terminologies and technologies is an important aim of this component.

Although the Center was designed to serve just one region of the country, the Southern California Region was seen as especially appropriate because of the large number of agencies, grass-roots activist organizations, private practitioners, and university-based researchers working in the field in this one geographic area. While the region may have considerably more resources than other parts of the country, the implementation and testing of the Center in that locality would have obvious impact in standards setting and modeling for other localities. Thus, while the Center itself may not be feasibly replicated due to financial constraints, the materials and methods developed therein would have substantial utility.

Rationale for a Delphi Study

Critical to the operation of the Center in its linking role between practitioners and resource system is to carry out research related to (1) ascertaining key concepts in the field of rape prevention and treatment, and specifying generally accepted standards and criteria for practice; (2) eliciting consensual judgments from practitioner and research experts concerning concepts and standards in areas where existing literature is inconsistent or uninformative; (3) providing the basis for the content and evaluation of services, primarily training and consultation. Relative to these purposes, the major data sources are resource literature addressed to rape prevention and treatment and the judgments of a panel of experts in those fields.

In the 1980's there is a need to stand back and assess to what extent consensus exists among knowledgeable workers in these fields regarding the underlying causes of sexual assault and violence toward persons, treatment approaches for victims and assailants, generally accepted standards and criteria for practice, and prevention strategies. The approach the SCRPSC is taking represents the beginning of a long-term process to define elements of an emerging national strategy designed to spearhead new public policy toward primary rape prevention. The strategy is based on an interactive process of information collection, analysis, and feedback, involving those who would be most directly affected by it. Furthermore, the strategy is designed to facilitate collaboration and resource sharing among the advocates of rape treatment and rape prevention.

Since the practitioners are scattered among different service delivery systems and disciplines, there has been little communication among treatment and prevention personnel regarding program scope, technique and evaluation. In addition, there has been even less opportunity for two-way communication between practitioner and researcher systems regarding effective implementation strategies for adapting research products to identified local problems. In order to facilitate the definition of a national strategy and the communication of that strategy among practitioners, researchers, and policy makers, the SCRPSC developed a major Delphi Study.

Delphi Procedures. Typically, research questions are approached by empirical confirmation methods. However, there are areas of judgment which are not readily amenable to empirical verification, for example, areas of policy decision-making. In such situations expert judgments have been used to arrive at group consensus.

In reviewing relevant literature in the sexual assault area, it became clear that there were some issues in which widespread agreement existed and could serve as a basis for formulating policies. However, the literature search also revealed areas of uncertainty or inconsistency regarding issues of considerable importance in establishing appropriate standards or practice for sexual assault prevention and treatment.

The Delphi technique, developed at the Rand Corporation in the 1950's is a method of determining group consensus among experts in the field. It has been used to formulate standards and to define priorities in emerging fields where such issues had not yet been resolved by research. This technique is capable of leading to group problem-solving in response to questions for which answers cannot be generated on the basis of extant hard data or well validated theories. Delphi procedures have been used for a vast array of applications in science, education, medicine, policy decision-making, and business. They are particularly useful in the sexual assault field where consensually agreed upon standards of practice or criteria related to sexual assault prevention and treatment are not yet available.

There are three key features of the Delphi Procedure:

1. anonymous response: judgments of the selected group of experts are obtained by structured, formal questionnaire methods. The questionnaire, accompanied by a set of instructions, guidelines, and ground rules, is typically a paper and pencil instrument; it may be administered by mail, in an interview, or at an interactive online computer console. While each participant may be informed of the total composition of the group, individuals are not allowed direct communication with one another and their item responses remain anonymous.
2. iteration and controlled feedback: the questionnaire is administered to participants for 3 or more rounds, and interaction is effected by systematic feedback of group responses between rounds. The responses from one round of questioning are subjected to some form of statistical treatment (usually a measure of central tendency, a measure of dispersion, or a frequency distribution) for each item. Such information accompanies all items in subsequent rounds of questioning. Feedback about how the entire group of experts responded to each item on the previous round is intended to facilitate development of consensus.
3. statistical group response: the group opinion is defined as an appropriate aggregate of individual expert opinions on the final round of the iterative procedure. Interaction with feedback is continued until convergence of opinion or "consensus" reaches the point of diminishing returns. Typically three rounds are sufficient for this purpose. Delphi procedures are designed to minimize the biasing effects of dominant individuals, of irrelevant communications, of face-to-face pressure toward conformity, and other aspects of group interactions that tend to delay conclusions or increase the margin of error. As a result, the procedure as a whole converges on the most adequate group response.

Organizational Design of the Delphi Questionnaire. The Delphi questionnaire was designed to take into account three specific research goals of the project: (1) formulating priorities among concepts in the sexual assault field; (2) recommending standards and practices; and (3) providing guidelines for evaluating treatment and prevention services. Such goals were assumed to involve concerns from a number of service areas including mental health, criminal justice, medical, and social service. These areas reflect the primary disciplines involved in treatment and prevention efforts concerning sexual assault.

In order to translate these goals into a viable instrument, the following framework was employed. The Delphi questionnaire was organized into four parts:

I. Intervention with Victims (juvenile and adult)
II. Intervention with Assailants
III. Primary Prevention
IV. Concepts/Definitions

For Parts I, II, and III, the Questionnaire attempts to determine major intervention goals, specific outcomes to be achieved, and tools needed by service providers to attain them. The questions in each part were thus organized under major headings, in this order

Goals: the primary intervention objectives to be attained.

Desired Outcomes: the specific outcomes to be achieved in order to meet the broader goals. These outcomes are listed in terms of what the victim or assailant or public will accomplish or receive through intervention.

Knowledge, Skills, Sensitivities of Providers: the characteristics and qualifications service providers need to possess for performing their functions adequately.

Special Considerations: the range and extent of consensus on value difference/dilemmas, as well as a set of principles by which service providers might guide their work.

Part IV, Concepts/Definitions, was included specifically because of definitional and conceptual confusion surrounding usage of intervention and prevention concepts in the sexual assault field. The last part of the questionnaire is devoted to formulation of appropriate definitions and labels for concepts related to sexual assault.

Rationale for the Linguistic Analysis of the Literature

As discussed previously, in the field of rape prevention and treatment there is much diversity in the service provider and research systems. Linguistic analysis offers a new and exciting level of investigation, including the values and beliefs held by representatives of the systems.

To investigate key concepts in the field of rape prevention and treatment and explore generally accepted standards and criteria for practice, we began by analyzing typical examples of relevant literature in this field. Currently three methods are available for performing such an analysis: (1) the ordinary, common-sense process of reading and summarizing; (2) content analysis, as developed in psychology; (3) linguistic treatment of structure and semantic characteristics as developed in discourse analysis. We chose the latter method, for reasons described below.

We want to systematically bring into focus background assumptions and presuppositions. As the findings of modern linguistics make clear, much of what is communicated in language resides not in its direct statements, but in values or beliefs which are communicated both directly and indirectly (for instance, by means of sentence structure or lexical choice). An ordinary reading of a text may notice and take account of these background assumptions but has no vehicle for bringing them to the foreground in an explicit way.

The method of content analysis does enable systematic analysis of written or spoken text by applying a set of coding categories. However, to our knowledge, no extant set of categories would be appropriate and complete for investigation of rape prevention and treatment literature. Rather, our aim was to locate basic concepts by a study of that literature.

For these reasons we have chosen to use a discourse analytic approach to representative articles in the literature. For the research design of this project, it is particularly important to discover category systems in the articles, rather than impose categories on them.

Discourse Analysis. A discourse analysis of texts assumes that text is made up of structures at every linguistic level (the word, the sentence, the paragraph, the section, and the entire text), and furthermore that structural information as well as the content itself can contribute to understanding what the author believes and asserts about the world. A multi-level analysis is made possible by a number of recently developed techniques in linguistics, described briefly below. (A detailed analysis of a sample text will be found in Chapter 2.)

Semantic Structures.

1. Speech formulas permit us to analyze the standard speaker and standard situation for use of certain types of fixed phrases (Fillmore, 1979). In analyzing speech formulas, the form of a phrase, rather than its content, is used to evoke context and speaker. This analysis allows us to specify a "default" author and a "default" situation for a text when such information is not specifically provided.

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2. Prototype semantics (Fillmore 1979) permits us to investigate the degree to which an author's use of a word corresponds to its usual central meaning. The idea is that any word in the language has one or more central meanings, which constitute the prototype for its use. Prototype semantics is particularly useful for analyzing texts in which the author's argument depends upon extending or limiting the prototypical meaning of a word in common use. This situation often arises in connection with use of the term "rape," so prototype semantic study could be especially helpful in examining literature for the purposes of this project.
3. Stylistic level reflects the degree of intimacy or distance assumed to hold between author and audience (R. Lakoff, 1979). Sudden increases in markers of distance indicate problem points in the text deserving close attention. They allow us to identify precisely areas where the author indicates discomfort.
4. Lexical clusterings are repetitions of words or synonyms for major concepts. They can be identified by fairly simple procedures and indicate the fundamental role of such concepts.
5. Presuppositions and entailments are propositions which must be assumed true in order for given sentences in a text to make sense. Their investigation allows us to determine background assumptions and provides a way of showing how speakers and writers indicate their beliefs without explicitly stating them (G. Lakoff, 1971; Gordon and Lakoff, 1971; Gazdar, 1979).

Syntactic Structures.

1. The syntax of individual sentences can provide cues for understanding a text. For instance, an important piece of information will be introduced in its own sentence, while an unimportant item is more likely to be introduced in a subordinate clause or prepositional phrase (Linde, 1974; Linde, 1974a; Ross, 1973.)
2. Syntactic presuppositions are analyzed to determine beliefs about the world indicated by the syntactic form of a sentence.
3. Syntactic structure of the text per se can also be described formally.

Structure in written text is often signalled by overt markers such as titles, section headings or section numbers. Structure may also be signalled by discourse level markers such as "in conclusion," "thirdly," "on the contrary," "however," and the like. Such markers direct the reader's attention to particular points in the underlying structure of the discourse.

Belief Systems. In addition to the levels of structure already discussed, the belief system of a text should also be taken into account. The overt statements of a text together with their presuppositions and the assumed relationship between author and audience, combine to form a system of beliefs about the way the world is or ought to be.

A notion particularly important for the study of belief systems is evaluation (Labov, 1972). Evaluative material expresses the author's opinion of what is important and what the audience should believe about what is heard or read.

CHAPTER 2: PROCEDURES

In moving from the theoretical perspective we have just discussed to a particular research approach, three main procedures were involved. The first was selecting a group of participants, the second was designing a questionnaire that would represent our major concerns, and the third was developing a plan for analyzing and presenting the resulting information we gathered.

Participants

An important initial activity was to enlist the participation of experts in the sexual assault field. Careful selection was of critical importance since the quality of outcomes of the Delphi process is dependent in large measure on the quality of the group whose expert judgments are elicited. With this in mind, the following procedures were employed in soliciting expert participation. The Delphi sample was gathered on a stepwise basis.

Criteria. The first step was to establish criteria for expertise in the area of sexual assault prevention and treatment. Five criteria served as the initial basis for nominating participants for both the National and Regional subgroups:

(1) a minimum of 4 years of experience in the field;
(2) recognized publications dealing with sexual assault treatment and prevention;
(3) recognized research in any aspect of sexual assault;
(4) recognized expertise based on public presentations (e.g., at conferences);
(5) representation of minority concerns.

A second set of guidelines for selection of participants arose from concerns about representing a variety of dimensions of relevant knowledge. The overall aim was to provide a reasonably representative distribution across each of the following areas: discipline or setting (mental health, medical, criminal justice, rape crisis centers, social service, university or research institution); type of sexual assault-related activities (prevention, treatment, research); age groups served (youth, adult); geographic region.

Procedure for Selection. Having established these criteria, the next step was to generate as exhaustive a list as possible of qualified candidates. The list was based on a thorough literature review together with recommendations from project staff, the project monitor, and other knowledgeable individuals acting in an advisory capacity.

The list of nominees was screened by the project staff to insure that expert qualifications were met in every case, to eliminate individuals who had worked with this project or could have a vested interest in the outcomes, and to insure the list was representative across fields of expertise.

After the screening process, a total of 123 letters soliciting participation were then sent out to all remaining qualified candidates.

Of the 72 National experts we asked to participate, 46 agreed; of the 51 Regional experts, 39 agreed. The initial sample, then, was 85. Those who declined to participate were evenly distributed over regions and across major selection dimensions. No special reasons apart from lack of time or interest were determined to explain initial refusals. Consequently we assume the obtained sample is reasonably representative of state-of-the-art thinking nationally.

Table 1
Questionnaire Sampling Schedule

Round	Date Sent	Return Date Requested	Actual Cut off Date	Number Returned	
				National	Regional
I	3/19/80	4/4/80	4/25/80	39	22
II	5/28/80	6/13/80	6/27/80	38	20
III	7/16/80	8/1/80	9/30/80	36	15

Schedule and Attrition. The schedule for the three questionnaire rounds (iterations) is described in Table 1. Since quick turnover is important to the success of the Delphi procedure, participants were asked to complete each round within two weeks. Follow-up postcards and telephone calls at the end of the second or beginning of the third week urged prompt return of the questionnaire by those who had not yet responded. Summarizing of responses for feedback could not begin until all questionnaires were returned. Actual cutoff dates allowed as much time as feasible to minimize attrition and yet institute the next round rapidly enough so that issues and procedures would not be forgotten by respondents.

Table 1 also shows the breakdown of returned questionnaires across the three rounds in the National and Regional groups. As the last two columns indicate, the greatest attrition in the sample occurred after round 1, the larger proportion of this attrition occurring among the Regional participants. Based on participants' comments, the major reason for respondent dropout was the overall length of the questionnaire.

Table 2

		Initial Acceptance		Returned Round I			Returned Round III		
	Total Sample	National	Regional	Total	National	Regional	Total	National	Regiona
Sex									
Male	22	15	7	17	13	4	14	11	3
Female	63	31	32	44	26	18	37	25	12
Ethnicity									
Caucasian	65	37	28	50	33	17	44	32	12
Black	4	2	2	2	2	0	1	1	0
Hispanic	6	1	5	4	1	3	1	0	1
Asian Pacific	2	0	2	1	0	1	1	0	1
Unknown	8	6	2	6	5	1	4	3	1
Geographic Region									
Northeast		13			12			11	
Southeast		11			7			6	
Northwest		14			14			12	
Central		8			7			6	
Southwest Regions									
I			2			2			2
II			33			17			12
III			3			2			2
IV			1			1			0
All Regions	85			62			51		
Setting									
Mental Health	30	19	11	21	16	5	17	15	2
Rape Crisis Center	20	9	11	14	6	8	12	6	6
Medical	9	4	5	7	4	3	6	3	3
Criminal Justice	13	5	8	5	3	2	4	3	1
University/ Research Inst.	13	9	4	12	9	3	12	9	3
Role									
Practitioner	56	21	35	34	15	19	26	14	12
Researcher/ Academic	21	17	4	20	17	3	19	16	3
Both	18	18	0	7	7	0	6	6	0
Professional Status									
Professional	67	37	30	50	33	17	42	30	12
Paraprofessional	13	4	9	7	2	5	5	2	3
Unknown	5	5	0	4	4	0	4	4	0
Areas of Expertise									
Treatment	59	32	27	41	27	14	35	25	10
Prevention	11	7	4	9	7	2	7	6	1
Both	13	5	8	9	3	6	9	5	4
Target Population									
Victim	57	29	28	40	24	16	34	23	11
Assailant	17	9	8	12	7	5	10	6	4
Both	11	8	3	9	8	1	7	7	0
Age of Target									
Juvenile	13	6	7	9	6	3	7	5	2
Adult	36	16	20	27	16	11	23	15	8
Both	29	17	12	25	17	8	21	16	5

Table 2 provides information about the demographic characteristics of the sample from round I to round III, revealing attrition patterns within particular types of respondent groups. Except for the regional differences described, no systematic respondent group attrition is observed.

Pooling the Sample. In order to make sure that Regional and National participants did not differ from one another either because of disproportionately high local attrition or through the effect of our dissemination effort in the region, responses from the two groups were carefully examined. No systematic differences were obtained, suggesting the feasibility of combining data from National and Regional respondents for subsequent analyses.(1)

Questionnaire Content

Generation of questionnaire content was a task undertaken concurrently with participation selection. Its overall aim was to examine extant sexual assault information and resource materials in order to establish currently relevant dimensions, concepts, and guiding assumptions of the field, and then to provide a framework for inquiry about these broad-based issues.

Search and Organization of Information. An extensive information base was developed in the following way. First, relevant resource material, conference reports, and treatment protocols were gathered. In addition, interviews were conducted with experts who had specialized knowledge regarding value conflicts in the field. The project staff carefully studied them to arrive at a preliminary agreement about major concepts, issues, and approaches. Recent sexual assault literature (1978-1979) was compared with earlier (pre-1978) literature to identify changes in state-of-the-art viewpoints and research findings. Written and verbal reports of conferences related to sexual assault were given special attention to locate areas of controversy regarding treatment or prevention. A similar process guided the reviewing of treatment protocols used by hospitals, rape crisis centers, and police departments.

On this basis, the staff selected a subset of representative materials for detailed linguistic examination. Each of the articles selected fell into at least one of the following categories: professional and lay approaches to sexual assault; prevention and intervention topic areas; intervention with adults or with juveniles; and traditional and non-traditional approaches. Using the discourse analytic method described above (Rationale chapter), we attempted systematically to document extant themes, values, beliefs, and assumptions.

(1) Had significant differences been obtained, the two samples would have been examined separately to delineate the ways in which our region is unrepresentative of national thinking.

An Example of Linguistic Analysis. The collection of background informa-information having been described, we can illustrate how discourse analysis proceeded. For this purpose we have chosen to explicate one example from the literature review that demonstrates most of the discourse analytic techniques discussed (see Rationale chapter).

This example constitutes the first section of a booklet entitled Rape: Lady Beware.

> The City attracts all types of people. Most of them are law-abiding citizens. But there are exceptions, and you have no way of knowing who is and who is not law abiding.
>
> In today's society, rape has emerged as one of the most serious and threatening crimes against women. In recent years, this crime has escalated at an alarming rate. For this reason, it becomes imperative that women realize the increasing potential danger to themselves from a rape attack. Rape is among the most frightening and violent of all crimes against women. The experience of being raped is a shock from which the victim never completely recovers.
>
> The most important thing to remember is that the rapist frequently plans his crime; he looks for the right chance and the easiest victim. Your best defense is to minimize his opportunity to attack you. Play it safe!
>
> Here are a few precautions which will greatly reduce your chances of becoming a victim.

The booklet has a cover page with the title and a composite picture including a woman lying on the ground with her legs spread and her clothing disarrayed, a 3 or 4 year old girl holding a door open, a woman standing by her disabled car at night, and a man's head, mainly in shadow. Absent is any indication of the author or institutional origin.

Semantic Cues. The text begins with a paragraph involving a number of presuppositions about the identity of the rapist. In speaking of all types of people, for example, it assumes that some of these people are not like us. Whether this is due to their race, their criminality, or other characteristics cannot be determined, but the implication is that they are different. Further, by saying that the city attracts all types, the text presupposes that these people are newcomers, not long-term residents of the city. This permits the additional inference that rapists are outsiders, not people like us or our acquaintances, boyfriends, husband, or fathers. In the text we notice also a cluster of words like increase, emerge, and escalate. This lexical clustering supports the presupposition that rape is more frequent now than it once was, and that, by implication, it will continue to increase.

The examination of speech formulas gives some indication of the booklet's authorship and point of view. The two best examples are law-abiding citizens and *crimes against women*. *As we mentioned in Chapter 1, law-abiding citizens* is typically used by members of the legal system or by people strongly identified with it. Crimes against women, on the other hand, is a phrase taken from the women's movement. It does not represent a legal categorization of crimes, as crimes against the person or crimes against property do. Thus, the standpoint of the text is multiple rather than single, and this impression is augmented by the fact that no affiliation is given.(1)

Finally, the word rape is used in a narrow but prototypical sense. The booklet assumes that rape is committed by a stranger, probably in a public place. This point is of interest because of the efforts of many groups to broaden the accepted or common meaning of the term.

Syntactic Cues. The most revealing syntactic pattern is the fact that the victim, the rape, and the rapist never occur in the same sentence. In the second paragraph, there is a discussion of the actual rape attack and its effects on the victim. In the third paragraph, there is a discussion of a potential rapist planning an attack, which may be foiled if the potential victim is prudent. That the victim and the rapist do not appear in the same sentence plus the fact that the rapist does not appear at all in the paragraph which is most serious and alarming suggest that the potential victim rather than the rapist is the active agent and that it is up to her to prevent the rape. This is fully consistent with the assumption of the rest of the booklet that nothing can be done either about potential rapists or about an unsafe environment, so that the burden of prevention is on the woman.

Belief System. The above examples sketch the major themes of the text and make it possible to collect the background beliefs it expresses. They cohere in a single belief system that includes the following points:

1. Rape is a problem of cities;
2. Rape is committed by strangers;
3. Rape is committed by people different from us;
4. Rape was once less of a problem than it is now;
5. Nothing can be done to change potential rapists and unsafe cities, so change is up to the potential victim;
6. Rape is the problem of the woman as an individual, not of women collectively.

It should be noted that these beliefs form a self-consistent and recognizible position in the spectrum of views about rape, although they are not explicitly asserted in the text.

---

(1) Subsequent to this analysis it was learned that the booklet was written by the Los Angeles Police Department and revised under pressure from local women's groups.

A detailed linguistic analyais can in this way bring to the foreground material that was initially in the background, and make explicit what was left implicit. This process inevitably alters the tone and impact of a text while rendering its contents (basic concepts and themes) accessible for further investigation.

Development of Overall Questionnaire Organization and Item Pool. The results of discourse analysis of resource information were subject to staff examination. Working from the extensive list of concepts and issues which emerged from that analysis, staff members with specific expertise generated detailed statements of a range of views within all prevention and intervention topics. For example, within the topic of assailant motivations for sexual assault, staff members attempted to portray explanations in current literature ranging from biological/instinctual to social/institutional. Project staff then met as a group to organize and structure the statements within the questionnaire framework.

Drawing on the outcomes of this process, the basic organization of the questionnaire and major dimensions of interest were decided. Four sections were selected to investigate intervention with victims (juvenile and adult), intervention with assailants, primary prevention, and sexual assault concepts and definitions. The first three sections were designed in parallel, with major dimensions focusing on goals, desired outcomes, and means of promoting them. Special considerations were also included in each, and a final section was needed to represent questions about key terms in the sexual assault field.

Once the overall framework was developed and relevant contents were identified, a method was needed for deciding what to include and what to eliminate. Issues were regarded as worthy of study on the basis of centrality to the sexual assault field; frequency of occurrence; severity of impact; relevance to practice of policy; and degrees of certainty or confusion. The overall goal in item selection was to choose a level of question specificity and a set of response alternatives capable of yielding information around which program contents and evaluations could be built.

Based on these guidelines, dimensions and concepts were posed as questionniare items by research staff and were submitted to program staff for final approval.

Response Formatting and Systematic Feedback. Originally an open-ended format was considered, but it was determined that such an approach would be both unwieldy and methodologically problematic for the Delphi process. Additionally, open-ended formatting would make aggregated feedback difficult. Instead, an objective format was developed to encourage systematic responding. For each question, respondents were provided with lists of response choices and also given an opportunity to add other responses they thought were important.

The response format most often employed was a five-point rating scale, supplemented by multiple choice and Yes/No questions. The questionnaire was precoded and precolumned for data entry directly from the response forms.

To inform respondents about other participants' judgments, we needed a method of displaying a summary of responses obtained from each round. We chose to present response distributions in terms of percentage of answers that fell in each response category for each question. This round-to-round feedback procedure was selected because it simply represented both central tendencies and dispersion in judgments. (See Appendix A for a sample questionnaire with feedback.)

Final Organization and Content of Questionnaire. A draft of the questionnaire was prepared. To evaluate its final content and format, it was pretested section by section. A minimum of two people not involved in the project but familiar with the focal issues participated in these trials. Based on this experience, the questionnaire was shortened in length and problematic items were reworded or reformatted. Further, the questionnaire itself was subjected to linguistic analysis to locate and eliminate potential value biases or conceptual confusions in its items or structure.

Respondents' comments about the questionnaire itself were also sought, since limited modifications were possible after the first round. Modifications after round I involved no additions; on the contrary, respondents indicated the necessity of shortening the questionnaire (which had required up to five hours for some to complete). Following round I, we eliminated all items that had already attained 90% or higher agreement. In addition, we removed questions regarded as ambiguous by respondents as well as questions left blank by at least half the respondents. However, because of the iterative nature of Delphi procedures, the wording of individual items could not be changed. Rounds II and III made use of an identical questionnaire that constituted a substantially shortened version of the first round instrument (this version appears as Appendix A).

TREATMENT OF DATA

The quantitative treatment of Delphi responses was planned to serve several purposes. First, we sought to identify and prioritize assertions that are strongly and consensually supported by experts in the sexual assault field. Second, we wanted to specify issues where consensus is lacking due to conflicting views, exploring the bases of disagreement. At the same time the analysis should help locate areas of general uncertainty, where more fundamental research would be needed. Finally, insofar as possible, we hoped to establish an analytic basis for combining and summarizing items to arrive at general conclusions.

The first step in satisfying these aims was to obtain a statistical description of responses, item by item, for each subset of the questionnaire. As we have noted, the simplest description seemed to be the percent of participants who selected each response category for any given item. In addition, we also calculated the average response (and the standard deviation) for each item. While all three rounds of answers are important, we gave closest attention to Round 3 in our initial investigation of consensus and priority of items among experts. Round 3 data were chosen for this purpose because at that point participants had had an opportunity to consider and reconsider both the questions and the kinds of judgments others were making; they thus represent final, deliberate opinions. Appendix A presents the percentage of participants who selected each response alternative for all items in the Round 3 questionnaire.

Consensus was identified within Round 3 responses in the following way. For all items where at least 5 response choices are given, "high consensus" is said to be achieved if, by the third round, 80 percent or more of the participants choose precisely the same response. An item is treated as "consensual" (but not highly so) if at least a simple majority of participants (50 percent or more) give the same response by that round. For example, the first item in Appendix A (questionnaire p. 2) attained high consensus, with 90% of participants agreeing to award it an importance rating of 5 by Round 3. In contrast, the next item on that page (Appendix A, questionnaire p. 2) attained only a simple majority, with 41% of respondents choosing an importance rating of 5 and another 49% rating it as a 4. In all tables of results in this report (e.g., Table 3, p. 23), consensual items are marked with an asterisk and highly consensual ones with a double asterisk.

Results themselves were examined first of all in terms of average importance ratings, which are used for the purpose of prioritizing goals or outcomes or methods. Specifically, the mean importance ascribed to each item was to generate a priority ordering for each subsection of the questionnaire.

TABLE 3
GOALS OF INTERVENTION WITH VICTIMS

Goals in order of importance	Average Importance[t]
**To assist victims in coping with the emotional impact of the sexual assault/abuse and to prevent further emotional distress	4.9
**To minimize the risk to potential victims of being sexually assaulted/abused	4.9
**To assist incest families in coping with the emotional stress associated with the sexual assault/abuse	4.9
**To assist victims in coping with the physical trauma associated with the sexual assault/abuse	4.8
*To identify sexually assaulted/abused individuals	4.3
*To assist victims in coping with the criminal justice system procedures	4.3
*To assist the families and friends of victims in coping with the emotional stress associated with the sexual assault/abuse	4.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .49.

Table 3 above, for example, presents victim intervention goals in order from highest to lowest importance based on their average Round 3 rating by participants. (It should be noted that the first three goals appear to be tied in importance, a reflection of our decision to round off important scores to the first decimal place; however, we looked as far as three decimal places to resolve ties in determining tabular order.) In addition, Table 3 also indicates the average standard deviation for importance ratings of the items in that questionnaire subsection (see superscript 't' in the footnote). This information is useful for interpreting the size of differences in importance among items; a reasonable assumption to make is that any difference about as large as the mean standard deviation (or larger) is fairly reliable. In terms of Table 3, for instance, the differences in importance among the first four victim intervention goals are very small; however the difference in priority between them and the remaining three exceeds the standard deviation and may be taken as a substantial one.

Data from all goal and outcome subsections of the questionnaire have been tabled similarly for ease of interpretation and comparison. That is, for each subsection items are listed in order of priority with their mean third round importance scores. Average standard deviations can be used to evaluate differences in priority while consensus markings provide an understanding of how widely a particular result is endorsed by participants; both are helpful for weighing the strength of conclusions from the first analytic task.

The second task for analysis was to investigate areas where participants' responses did not converge even after three rounds of questioning. Lack of consensus would seem to signal either conflicting viewpoints among groups of participants or else a general uncertainty. Potential disagreements were explored by analyses of variance; first round data were used for this purpose since responses were wholly independent at that point and initial differences in judgment would be clearest. Since we had already learned that regional differences were virtually nonexistent, we chose three other participant variables for examination--sex, setting, and role. (See Table 2, pg. 13, for a complete list of participant variables.)

Issues in sexual assault may well be viewed differently by male and female respondents. Further, it seemed just as likely for different types of work settings to be predictive of differing beliefs or assumptions. Accordingly, for analytic purposes we distinguished three participant settings: rape crisis centers, whose focus is uniquely on sexual assault; mental health settings, more generically oriented toward psychological disturbance; and others (medical, legal, academic). Finally, differences in perspective could also be expected as a function of role; participants were grouped on the basis of whether their activity in the sexual assault field involved primarily service provision, primarily knowledge-gathering, or both. These three participant variables were treated as independent factors in analyses of variance with responses to relatively low consensus items serving as dependent measure. (It should be noted that differences in sex and setting are partially overlapping, since rape crisis centers employ substantially more women than men. While small cell sizes precluded a two-way analysis, it is not in fact difficult to separate interpretively the contribution of these two sources of variation.)

Significant differences between groups of participants in response to questionnaire items are interpreted to mean that consensus has been impeded in part by disagreements related to sex, setting or role. Here statistical significance represents a confidence level of .05 or stronger. Such issues can be fruitfully pursued by between-group exchanges oriented toward clarification of values, beliefs and assumptions. On the other hand, where lack of consensus does not reflect such disagreement it is assumed to index areas of insufficient knowledge or areas where shared standards and practices have not developed. In these areas, further research is warranted. Information about disagreement and uncertainty is presented immediately after information about consensus and priority throughout the discussion of results below.

Thus far our discussion of data analyses has been limited to item-level concerns. The last analytic efforts described here operate on groups of items to address substantive or methodological questions. One substantive goal of the research was to organize information about sexual assault intervention and prevention. In part this aim is fulfilled by the systematic study of resource literature, explained above. In part it is fulfilled analytically, by attempting to discern underlying structures in selected subsets of questionnaire data. Generally, the longest questionnaire subsections (as a glance at Appendix A will confirm) are those that concern methods--what service providers can do to promote desired outcomes (e.g., pp. 9-10) or to prevent undesirable ones (e.g., pg. 28). Each group of items dealing with practitioner knowledge, sensitivites and skills was subjected to factorial analysis; these analyses, presented near the end of each major result section, suggest that means for achieving outcomes can appropriately be construed in terms of more generic dimensions of practitioner activity.

Analyses undertaken for methodological purposes aimed at assessing reliability and change in questionnaire responses. Because the Delphi procedure involves not only repetition but also feedback, calculation of test-retest reliability was unfeasible. However, to insure that items had approximately similar meanings to everyone, Round 1 participants were randomly divided into two groups and the correlations between their responses obtained. The very high coefficients produced by this exercise (average correlation = .98) suggest that questionnaire items are fairly reliable, and differences emerging in data analyses can be taken as real rather than artifactual. Finally, to corroborate the assumption that Delphi procedures facilitate the convergence of responses toward consensus, we investigated round to round changes in data. Difference scores generated by subtracting Round 1 from Round 3 responses showed (by their sign) that participants typically moved toward the modal response category from point of origin, a result that had been expected on the basis of increasing numbers of consensual and highly consensual items over time.

CHAPTER 3: RESULTS

The following chapter reports the results of the quantitative study of the data (in the manner just described above). Our overall aim was to present as much descriptive material as possible so that the readers can make use of the findings and can draw their own interpretations from the results.

We ran a large number of tests because of the scope of the issues and because we wanted to examine the data in a variety of ways. This means that we run the risk that some of the tests could turn out to be significant by chance alone.

This chapter is a lengthy one--covering the four Questionnaire sections. As we noted earlier, the results are presented in the order they appeared in the Questionnaire (see Appendix A).

Victim Intervention

As noted earlier, the questionnaire begins by inquiring about intervention with victims. It first addresses goals for intervention, and then outcomes related to these goals; last it asks about methods for achieving these goals and other special considerations (for the actual items, please refer to Appendix A). The results are discussed in the same order here.

TABLE 3
GOALS OF INTERVENTION WITH VICTIMS

Goals in order of importance	Average importance[t]
**To assist victims in coping with the emotional impact of the sexual assault/abuse and to prevent further emotional distress	4.9
**To minimize the risk to potential victims of being sexually assaulted/abused	4.9
**To assist incest families in coping with the emotional stress associated with the sexual assault/abuse	4.9
**To assist victims in coping with the physical trauma associated with the sexual assault/abuse	4.8
*To identify sexually assaulted/abused individuals	4.3
*To assist victims in coping with the criminal justice system procedures	4.3
*To assist the families and friends of victims in coping with the emotional stress associated with the sexual assault/abuse	4.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t]5-point scale of importance, with a mean standard deviation of .49.

Table 3 presents several kinds of information about the seven goals for intervention with victims. The goals are listed in order of importance with the average importance rating for each given in the right-hand column. Footnotes help interpret the degree of consensus (by asterisks) and the significance of differences in importance among goals (average standard deviation). As the table shows, the top four goals are regarded as very important--almost equally so. They differ markedly in importance from the last three items. This interpretation is confirmed by the fact that the fifth goal receives an importance rating lower by at least one standard deviation than the lowest of the top priority goals. As it happens, we also found very high consensus among experts about the top four goals; that is, 80 percent or more of the respondents gave them identically high importance ratings by the third round. In contrast, there was less agreement about the importance of remaining goals; here concurrence ranged from 50 to 79 percent. An examination of round-to-round changes in judgments about victim goals showed small but consistent increases in importance ratings for all but the last. The goal of assisting families and friends of victims was regarded as progressively less important with each re-evaluation.

Having looked at questions of overall importance and consensus, we next attempted to find out whether victim intervention goals were approached differently by any specific subgroup of respondents. We found no differences based on sex or setting. We did, however, find differences based on role. The goal of minimizing risk to potential victims was judged significantly more important by those engaged in both service and research than by those who pursue either role exclusively ($F = 3.50, p < .05$). In contrast, assisting family and friends of victims was rated more important by service providers than by researchers or those engaged in multiple roles ($F = 3.45, p < .05$).

In general, analysis of these data yielded a straight forward picture of the relative consensus and importance of victim intervention goals. While all seven warrant careful attention, a priority ordering is established that should be helpful for policy and planning in sexual assault intervention. The succeeding sections present information about outcomes associated with each of these goals in the order of importance given.

TABLE 4
VICTIM OUTCOMES FOR GOAL:
To assist victims in coping with the emotional impact of the sexual assault/abuse and to prevent further emotional distress

Outcomes in order of importance	Average importance[t]
**The victim has a restored sense of self-worth	5.0
**The victim feels understood and believed by the service provider concerning her/his assault/abuse experience	5.0
**The victim understands and anticipates her/his own emotional reactions to the assault/abuse	5.0
**The victim has a support system of family, friends and/or peers which assists her/him cope with the assault/abuse	5.0
**The victim has the coping skills to reduce her/his vulnerability to repeated assaults/abuse	4.9
**The victim understands that the responsibility for the assault/abuse lies with the assailant	4.9
**The victim is coping at her/his previous level of psychological functioning or higher	4.9
**The victim's living situation provides a safe environment	4.8
**The victim's emotional symptoms of distress have decreased	4.8
*The victim and her/his family and friends have the necessary information concerning reporting options	4.7
*The victim expresses the range of different feelings she/he has experienced concerning the assault/abuse	4.7
*The victim has a restored sense of trust in other people	4.0

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .36.

Results from the study of victim intervention goals (above) serve to organize subsequent findings about outcomes. That is, outcomes are discussed in order of importance of the goal they serve. The first set of outcomes, presented in Table 4, are those related to the victim intervention goal given highest priority: to assist victims emotionally. As Table 4 shows, outcomes for the most part were judged uniformly very important. The one exception--the outcome receiving the lowest--was restoring the victim's sense of trust in others. Its importance score was more than a standard deviation away from the score of the adjacent item in the table. This outcome was one of the few to exhibit systematic decreases in importance over rounds. Remaining outcomes, in contrast, are not viewed as markedly different from one another in importance.

With respect to consensus a similar pattern appears, most of the items being highly consensual. It is noteworthy that the first four outcomes, all having to do with emotional support or emotional benefits, in fact obtained 100% consensus by round three. These data suggest that assisting victims to cope with the emotional impact of sexual assault is a clearly defined goal with well understood outcomes.

TABLE 5
VICTIM OUTCOMES FOR GOAL:
To minimize the risk to potential victims
of being sexually assaulted/abused

Outcomes in order of importance	Average importance[t]
**The incidence of sexual assault/abuse among high-risk individuals is reduced	4.9
**Community environments are structured to provide safety and protection of individual residents	4.9
**Potential victims are aware of the risks of their environment and actively plan to minimize them	4.9
**Potential victims are aware of safety measures against sexual assault/abuse	4.8
**Potential victims have good support systems in their community	4.8
**Potential victims understand the nature, scope and severity of sexual assault/abuse	4.2
*Educators have information on how to detect high-risk children and families	4.1
*High-risk individuals and vulnerable segments of the population are identified	4.1
*Service providers have skills in identification of high-risk individuals	4.1
*Potential victims know self-defense and other protective skills	3.9

**High consensus (consensus = 80 percent of respondents in importance rating).
*Consensus (consensus = 50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .52.

Outcomes related to the second-priority goal--minimizing sexual assault risk to potential victims--are given in Table 5. In view of obtained disagreements about the importance of this goal (see above), it is not surprising to find variation in degree of consensus and importance among the associated outcomes. Here the top five outcomes essentially receive similar and high importance ratings, while the lower five differ in importance by at least one average standard deviation. This pattern is nearly replicated by differences in degree of consensus.

It is worth noting that the five most valued outcomes have to do with reducing incidence of sexual assault primarily through environmental and safety factors; in contrast, the others concern identifying, informing and training potential victims. This contrast is particularly interesting in the context of present practice, which places considerable emphasis on self-defense skills--the item rated lowest in importance in this group. In general, lower-rated outcomes tend to be more indirect and long-range strategies than are the top rated items in this section.

Examination of round one items lowest in consensus and importance in terms of participant variables yielded virtually no between-group differences. Only one outcome (informing educators how to detect high-risk children and families) showed significant variation--service providers rated this outcome significantly higher than those engaged in dual roles, who in turn rated it higher than researchers ($F = 5.08$, $p < .01$). Finally, in this set of outcomes, we again found just one (potential victims are aware of, and actively minimize, environmental risks) whose importance ratings declined from round 1 to round 3.

TABLE 6
VICTIM OUTCOMES FOR GOAL:
To assist incest families in coping with the emotional stress associated with the sexual assault/abuse

Outcomes in order of importance	Average importance[t]
**The family has understood and coped with the emotional impact of the sexual assault/abuse	5.0
**Family members use appropriate community services to prevent further incidents	4.9
**Child victim's account of the sexual abuse is believed by all family members	4.9
**Communication among family members is improved	4.8
**Family members are coping at their previous level of functioning or higher	4.8
**All family members hold the sexual abuser accountable for his/her actions	4.8
**All family members use new and/or improved ways to deal with conflicts and stress	4.7
*Family members have appropriate roles in the family system	4.4
*The family has an improved sense of trust among all its members	3.8

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .64.

Outcomes related to the goal of assisting incest families with stress coping are generally rated as very important by participants (see Table 6). The exception to this rule is the lowest ranking outcome--family has an improved sense of trust--whose importance rating is about one average standard deviation lower then even the next-lowest item. Consensus about most of these outcomes is high as well--

all but two reached 80 percent or more agreement on the specific importance ratings given.

One lower-consensus outcome concerns improving the family's sense of trust, already singled out as lowest in importance. Interestingly, this item is the only one in the set whose importance scores decreased from round to round. On the basis of written comments from some respondents, we suspect that hesitancy in endorsing this outcome reflects participants' belief that the restoration of family trust should depend on whether or not that environment is actually trustworthy. In contrast, believing the victim achieves both high consensus and high importance.

TABLE 7
VICTIM OUTCOMES FOR GOAL:
To assist victims in coping with the physical trauma associated with the sexual assault/abuse

Outcomes in order of importance	Average importance[t]
**The victim and her/his family and friends have the necessary information concerning how the medical procedures will be conducted	5.0
**The victim and her/his family and friends receive necessary emotional support services needed to deal with the physical trauma	5.0
**The victim feels understood and believed by the medical service providers	4.9
**The victim's physical condition is restored to her/his previous level of functioning	4.9
**The victim's confidentiality is maintained	4.9
*The victim receives medical treatment which meets the legal requirements for reporting and for evidence collection	4.7
*The victim and her/his family and friends understand the reporting options available	4.7

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .42.

Last among the top priority goals is assisting victims to cope with the physical trauma. Outcomes associated with this goal (see Table 7) received uniformly high importance ratings, exhibiting no substantial differences in value. Similarly, a high level of consensus (80% or higher) characterized most of the responses. However, the importance of two outcomes--both involving constraints on medical and reporting procedures--was less clear to participants. These items received ratings that were consensual but not highly so (50-79% agreement).

Table 8 presents results for outcomes related to the goal of identifying sexual assault/abuse victims; this goal ranked in the lower half of the priority ordering of victim intervention aims (cf. Table 3). As Table 8 shows, associated outcomes vary in importance. Participants placed greatest emphasis on reducing repeat incidence among victims and on development of detection and referral skills. Substantially less importance was accorded to enforcement of reporting laws and

TABLE 8
VICTIM OUTCOMES FOR GOAL:
To identify sexually assaulted/abused individuals

Outcomes in order of importance	Average importance[t]
**Repeated incidence of sexual assault/abuse is reduced among sexually assaulted/abused individuals	5.0
**Service providers have skills in early detection of sexually abused/assaulted individuals	4.9
*Community members have information on how to detect and refer possible sexual assault/abuse situations	4.7
*Laws regarding reporting of sexual assault/abuse incidents are enforced	4.3
*All sexually assaulted/abused individuals are identified	4.1
*Sexually assaulted/abused individuals contact sexual assault services	4.1

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .65.

to identification of and contact with all victims. Variation in consensus is apparent as well, with only the first two outcomes showing high accord. The remainder attain only moderate consensus, making this the least consensual set of victim intervention outcomes.

To determine whether relatively low consensus in this outcome set reflected conflicting values among participants, analyses of variance were carried out on round one responses. One outcome--enforcement of reporting laws--elicited significant disagreement on the basis of both setting and role. In the case of setting, rape crisis center practitioners ascribed this outcome significantly less importance than mental health practitioners, and they in turn rated it significantly lower than remaining participants ($F = 3.43$, $p < .05$). With respect to role, researchers valued enforcement of reporting laws more highly than either practitioners or those engaged in dual roles ($F = 3.58$, $p < .05$). Lack of consensus about the value of strict enforcement of reporting laws thus appears to be explained in part by between group differences in viewpoint. However, lack of consensus about attempts at universal identification and contact seems to represent value uncertainty rather than value conflict.

In contrast to the preceding section, Table 9 shows considerable clarity about outcomes related to the goal of assisting victims to cope with the criminal justice system (even though this goal too received a relatively low priority among victim intervention aims). All tabled outcomes are seen as very important parts of providing such assistance although the last two--a minimum number of interviews and a victim advocate within the criminal justice system--were distinguished as least critical. As the asterisks in Table 9 indicate, there is a high degree of

TABLE 9
VICTIM OUTCOMES FOR GOAL:
To assist victims in coping with the criminal justice system procedures

Outcomes in order of importance	Average importance†
**The victim's civil rights are protected	5.0
**The victim and her/his family and friends have the necessary information concerning the legal procedures and the investigation	5.0
**The victim feels understood and believed by criminal justice service providers	4.9
**The victim is interviewed in her/his own language	4.9
*The victim is interviewed a minimum of times	4.7
*The victim has someone from within the criminal justice system who is negotiating for her/him	4.6

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
†5-point scale of importance, with a mean standard deviation of .31.

consensus about the most important outcomes. It is noteworthy that with respect to the most highly valued objectives--protection of victims' civil rights and provision of adequate information about legal procedures--participants achieved a 100 percent consensus.

TABLE 10
VICTIM OUTCOMES FOR GOAL:
To assist the families and friends of victims in coping with the emotional stress associated with the sexual assault/abuse

Outcomes in order of importance	Average importance†
**Parents of child victims have the knowledge to assist in the child's sexual and social adjustment to the sexual assault/abuse	5.0
**Victim's family and friends have understood and coped with the emotional impact of the sexual assault/abuse incident	4.9
**Victim's family and friends take an active role in emotionally supporting the victim	4.9
*Victim's family and friends understand and can express their own set of emotional reactions to the assault/abuse	4.7
*Victim's family and friends have a support system which assists in their coping with the impact of the sexual assault/abuse	4.7
*Victim's family and friends have made effective use of available community resources	4.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
†5-point scale of importance, with a mean standard deviation of .38.

Information about outcomes related to the last victim intervention goal, assisting families and friends to cope, appears in Table 10 above. Again, while the goal was low in the priority order, judging the relative importance of associated outcomes was not problematic for respondents. They judged that assisting incest families to promote the sexual and social adjustment of child victims was of highest importance and attained 100 percent agreement.

Other outcomes focusing on the emotional recovery of family and friends and their potential role in supporting the victim were also highly valued and elicited high to moderate consensus. Only the last--effective use of community resources by family and friends--received an average importance rating that is lower than the others by at least one standard deviation. There was, however, some participant disagreement about value assignment to this outcome. Rape crisis center practitioners gave greater importance to effective use of community resources by family and friends than did mental health practitioners, who nevertheless rated it higher than participants from other settings ($F = 5.81$, $p < .01$).

The victim intervention portion of the questionnaire contains as its last regular section a set of 22 items dealing with the knowledge, sensitivities and skills needed by service providers in sexual assault. As explained in the Procedures chapter, long sections such as this one were examined factorially after regular analyses had been conducted. Results related to importance ratings and degree of consensus appear in the left half of Table 11 in their usual format while factorial information appear to the right.

It is evident from the data in Table 11 that participants regard these provider skills as very important on the whole. In fact the four top priority abilities (being able to conduct interviews nonjudgmentally, ethically and responsibly so as to communicate respect and concern and to minimize the chance of further stress) were accorded the highest importance score (5) with 100 percent agreement among respondents. On the other hand, the five lowest ranking items are distinctively less valued, their mean importance ratings falling at least a standard deviation below those of high priority abilities; these items consistently decreased in judged importance across rounds. A range of consensus is apparent, with higher rates of agreement about more highly valued skills. It should be noted that, for the first time in the victim section, two items fail to attain consensus at all--ability to communicate knowledge about human sexuality and to collect evidence in accord with legal requirements. These low priority skills did not elicit a majority of responses (51 percent or more) in any one response category. The lack of consensus was not reflective, however, of specific disagreements between participant groups. We therefore interpret it as indicative of general uncertainty about the value of the skills in question for victim intervention.

To establish a more integrated understanding of provider skills, the 22 items were subjected to factor analysis. Our aim was to see whether a smaller number of more broadly describable skill categories could be generated as a basis for grouping specific abilities. Solutions were requested using three, four and five

TABLE 11
KNOWLEDGE, SENSITIVITIES AND SKILLS INVOLVED IN VICTIM INTERVENTION

Knowledge, skills, sensitivities in order of importance	Average importance[t]	Factors I	II	III	IV
**Ability to conduct interviews in a non-judgmental manner	5.0	.47			.52
**Ability to communicate respect and concern for the victim and her/his feelings during interviews	5.0	.72			
**Ability to conduct interviews in an ethical and responsible manner	5.0	.78			
**Ability to provide sensitive and effective intervention which minimizes the chance for any further emotional stress	5.0	.65			
**Ability to adjust intervention choice and approach according to the developmental stage of the victim	4.9			.51	
**Ability to apply knowledge of the psychological and social dynamics of sexual assault to intervention with individual victims	4.9		.48	.48	
**Ability to provide intervention which takes into account the cultural background of the victim's family	4.9		.55		
**Mastery of crisis intervention techniques	4.9	.43			
**Ability to use community resources effectively	4.8	.50		.49	
*Ability to obtain needed information from the victim and her/his family and friends in a nonintrusive manner	4.7				
*Ability to assist family and friends of victim in using and coping with their own emotional reaction to the sexual assault/abuse	4.7		.70		
*Personal insight of own reactions/attitudes toward sexual assault	4.7	.58			
*Ability to identify specific emotional reactions the victim may be experiencing	4.7		.81		
*Ability to cope with one's own job-related stress and to find effective means of stress reduction	4.7	.60			
*Ability to adjust intervention choice and approach according to the type of sexual assault/abuse	4.6			.47	
*Ability to explain criminal justice system procedures	4.5	.58		.62	
*Ability to explain medical procedures	4.5			.62	
*Ability to identify specific emotional reactions the victim's family and friends may be experiencing	4.3		.91		
*Ability to accurately identify sexually abused/assaulted individuals on the basis of clinical information	4.3		.41	.44	.41
*Ability to identify high-risk individuals	4.0			.45	.87
Ability to communicate knowledge regarding physiological and interpersonal aspects of human sexuality to victims	3.9			.73	
Ability to collect evidence in accordance with regional/state legal requirements	3.8			.58	

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .45.

factors; examination of the results indicated that while three factors were too few to account adequately for response variation, five were too many. Consequently, Table 11 presents a four-factor solution that accounts for a reasonable proportion of the variance (63 percent), and is interpretable and consistent with the descriptive discussion above. In the table, factor identifications appear at the top. When any specific ability is substantially associated with a factor, its factor loading is given in the appropriate column. The higher the factor loading, the more strongly is the particular skill associated with the general factor; so highest loading items are most useful for interpreting the underlying dimensions.

The factor which accounts for the largest share of the variance (33%) not surprisingly includes the skills deemed most important in the main by participants, and is called in the table GENERIC INTERVIEW SKILLS (Factor I). This first factor is defined by high priority abilities having to do with ethical and sensitive provider behavior that communicates respect and concern to victims. These, together with a number of other items loading on the factor, support the interpretation of the underlying dimension as representative of general highly desired interviewer qualities that do not presuppose knowledge of sexual assault or therapeutic techniques, nor require a special setting or practitioner role.

The second factor, accounting for 12% of the variance, is characterized by practitioner capability to identify and support coping with specific emotional reactions to sexual assault by victims and their families and friends. Similarly, other skills loading on this factor have to do with applying clinical information plus knowledge of psychological and social dynamics of sexual assault and the victim's cultural background in the delivery of individual interventions. We refer to this factor as INTERVENTION PROCEDURES because associated abilities presuppose an understanding of psychotherapeutic foundations for treatment and the capacity to apply them specifically in the design of sexual assault interventions with individual victims.

A more cognitive orientation is salient in Factor III, which explains 11% of the variation in responses. Factor III is called EFFECTIVE KNOWLEDGE BASE because it is typified by such items as ability to communicate knowledge of human sexuality and ability to explain criminal justice and medical procedures to victims. These skills depend on competence in acquiring and making use of specific and relevant resource information. The last factor (Factor IV), accounting for 7% of the variance, is distinguished by identification skills (e.g., ability to identify the high-risk individuals). It is consequently labeled IDENTIFICATION

OF INTERVENTION TARGETS. While this general capability may make use of clinical information, previous responses from participants (see Table 8) indicate the feasibility of broad dissemination of detection and referral skills throughout the community.

As we have mentioned, questions about "Special Considerations" end each section. Special considerations involving victims of sexual assault (see Appendix A, pp. 11-16) have been grouped by means of three major themes: 1) factors guiding effective intervention; 2) issues specific to intervention with juvenile victims; and 3) working relationships involving mental health and criminal justice systems.

TABLE 12
FACTORS GUIDING EFFECTIVE TREATMENT OF VICTIMS

Factors in order of importance	Average Importance^t
**Victim's responses to assault	4.9
**Victim's ability to adapt to stress	4.9
**Individual aspects of trauma associated with sexual assault	4.8
**Relationship of victim to assailant	4.8
**Conscious processes of victim	4.8
*Developmental life stage of victim	4.7
*Duration of assaultive relationship	4.5
*Victim's cultural background	4.2
*Victim's family's ability to adapt to stress	4.1
*Phases of victim's reactions	4.0
*Generic features of trauma reactions	3.9
*Unconscious processes of victim	3.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
^{t}5-point scale of importance, with a mean standard deviation of .59.

Guideposts for intervention are presented in Table 12. In the set of 12 possible guiding factors, seven have relatively high importance ratings. Of these, three have to do with adaptability to stress or assault, two have to do with relationship to assailant, and two with basic psychological features (conscious processes and developmental life stage of the victim). Unconscious processes of victim and generic features of trauma reaction, in contrast, were accorded significantly lower priority. Most of the high importance factors also achieved strong consensus and none of the suggested treatment guides failed to attain at least a consensual majority.

In general, these data suggest that respondents think effective intervention is guided by consideration of very individualized needs and abilities of victims, with most emphasis on what is available to conscious awareness. They also give greater importance to needs of victims than to those of victims' families and friends. These conclusions are, however, conditioned in two way. First, analyses of variance indicated that those who provide services regard unconscious processes of victims as substantially more effective treatment guides than either researchers or those engaged in dual roles do ($F = 8.19$, $p < .001$). The family's stress adaptability, in contrast, was valued significantly more by rape crisis practitioners than by representatives of other settings as a factor guiding effective victim intervention ($F = 3.70$, $p < .05$).

The question of whether juvenile or adult victims necessarily need counseling to recover from sexual assault trauma afforded only a yes/no response choice. When the victim is specified as an adult, respondents are divided almost evenly as to whether or not counseling is necessary (52% yes, 48% no); interestingly, those engaged in dual roles are significantly more likely than either practitioners or researchers ($F = 3.49$, $p < .05$) to answer affirmatively. For juvenile victims, however, a majority of respondents (79%) see intervention as necessary.

TABLE 13
OBSTACLES IN TREATMENT
OF JUVENILE VICTIMS

Obstacles in order of importance	Average importance^t
**Limitations of available options for protecting an abused child	4.8
**Lack of knowledge concerning child sexual abuse treatment	4.8
*General vulnerability/powerlessness of children in the adult world	4.6
**Socialization process which makes children, especially females, vulnerable to victimization	4.6
Difficulty in communicating with a child about sexuality	3.7
*Lack of knowledge concerning child development	3.2
Child's fear of treatment systems	3.1
*Interviewer's anger toward assailant	2.8

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
^{t}5-point scale of importance, with a mean standard deviation of .79.

A more detailed question about intervention with juveniles inquired about possible obstacles to treatment. As Table 13 shows, the most serious obstacles were seen as limited options for protecting abused children, lack of knowledge about treatment, and the general vulnerability of children. Remaining potential barriers were given substantially lower importance ratings. For the most part, judgments about the most important obstacles were highly consensual. In addition, there was moderate consensus about the relative unimportance of two proposed obstacles, interviewer anger toward the assailant and lack of child development knowledge. Two listed choices--difficulty in communicating with a child victim about sexuality and a child's fear of treatment systems--did not elicit consensual judgments. It should be noted that lack of consensus here is not reflective of conflicting perspectives among respondent groups but rather reflects absence of a common understanding about juvenile victim intervention.

Another set of items about juvenile victims inquired about criteria for reporting sexual assault/abuse. The two criteria seen as most important--and the only two that attained even moderate consensus--concerned legal requirements and social supports available to the child. Other potential criteria (relationship of child to assailant, effect on treatment, and child's age) are substantially lower in priority and do not achieve consensus. In only one instance is nonconcurrence of responses explained by between group differences; rape crisis practitioners are significantly more likely than participants from other settings to view its likely effect on treatment as a criterion for deciding when to report juvenile sexual assault ($F = 3.26$, $p < .05$).

Special considerations about victim intervention also included a number of items focused on the service delivery system. Two concerned the appropriateness of male service providers. A two-thirds majority of participants agree that male counselors can be used with female victims; a much greater majority (82%) endorse the use of male providers in prevention programs. However, these responses were conditioned both by sex and setting of participants. With respect to sex, female participants were significantly less likely than their male counterparts to approve of the use of male counselors for victims ($F = 4.45$, $p < .05$). In addition, rape crisis practitioners were more likely to disapprove of using males either for intervention or for prevention than were participants from other settings ($F = 5.11$, $p < .01$ and $F = 9.76$, $p < .001$, respectively). (These latter qualifications are partially interdependent since, as we have noted, women are overrepresented among rape crisis center respondents in our sample.) In contrast, virtually all the participants (92%) agreed that, at least in intervention with children, the sex of the victim should be taken into account in guiding treatment.

TABLE 14
WORKING RELATIONSHIPS TO ESTABLISH BETWEEN MENTAL HEALTH AND CRIMINAL JUSTICE SYSTEMS

Relationships in order of importance	Average importance[t]
**Mental health provides consultation to criminal justice system in dealing with victims and their families	4.9
**Collaborative training programs are conducted	4.8
*Criminal justice system provides consultation to mental health system in dealing with victims and their families	4.7
**Criminal justice worker calls in mental health provider at first contact with child victims and their families	4.6
*Ongoing case conferences are set up between two systems	4.6
Collaborative research projects are undertaken	3.9

**High consensus (consensus=80 percent of respondents in importance rating).

*Consensus (consensus=50 percent of respondents in importance rating).

[t] 5-point scale of importance, with a mean standard deviation of .77.

A series of six items attempted to tap the value of different kinds of working relationships between mental health and criminal justice systems for service delivery to victims. The results, presented in Table 14, show that with the exception of collaborative research projects, the proposed working relationships all were highly valued by participants. Among them, consultation by mental health professionals to the criminal justice system and collaborative training programs received highest priority. The pattern of obtained consensus approximately reflected importance ratings, the least important item being the only one not to elicit agreement.

The exploration of special considerations related to victim intervention concludes with a series of "forced choice" questions (see Appendix A, pp. 15-17). These items require respondents to make difficult either/or decisions assuming limited available options or resources and incomplete information (a situation that not infrequently confronts service providers). For example, the first forced choice item (number 8, p. 15) asked whether secondary prevention training should emphasize strategies of avoidance or assertiveness. By the third round, 82 percent of the participants approved the latter, recommending teaching of non-victim-like behavioral and attitudinal techniques.

One question explored potential victim self-destructiveness as a treatment focus, posing the hypothetical situation of an assaulted hitchhiker. Respondents were about evenly divided as to whether intervention should assure the victim she had no responsibility for the event or should explore decision points in her experience to see whether or not she had made self-destructive choices. On the other hand, given a vignette involving the rape of a middle-aged parent who subsequently felt "dirty"and disgusted by sex, respondents concurred (86%) that intervention should emphasize the violent (rather than sexual) aspects of assault.

Three clinical vignettes concerned with decisions involving incest victims also attained a fair level of consensus. With regard to helping a young teenage victim deal with intense anger, respondents rejected the acknowledgement of powerlessness in the family in favor of an intervention encouraging the victim to express her anger toward her parents during a counseling session (94%). There was also support for reporting a long-term father-son abuse even though the eleven-year-old denied his initial disclosure for fear of its impact on the family (86%). Responding to a question about options for a protective living environment in the same hypothetical situation, a majority of participants (78%) approved arranging for the father to leave the household.

Three final questions explored problems of intervention with ethnic minority victims. In the hypothesized emergency case involving a hispanic victim, 76% of the respondents believed that the non-hispanic service provider should continue with counseling rather than attempt to find another counselor from the same culture. On the other hand, 90% of the participants endorsed the strategy of supporting the victim's choice of coping with anticipated family problems by nondisclosure. Finally, 90% of the participants recommended encouraging such a victim to continue with counseling even though it would be contrary to the practices of the victim's culture and to her own desires.

As we explained in the Procedures chapter, Round 1 Questionnaire sections provided spaces in which respondents could add to lists of closed-ended responses any important choices they thought should be included. An examination of written additions yielded no items consensually suggested by at least 25 percent of participants. While no participant-supplied items formally warranted inclusion in subsequent Questionnaire rounds, several are worth noting. With respect to victim intervention, one additional goal was suggested by a number of respondents--increasing public understanding of feminist views of sexual assault. Later, in relation to special considerations, several respondents added availability of community and social support for the victim as a guideline for designing effective victim intervention.

Victim Intervention Summary

Participants strongly agreed that the following four intervention goals, as well as outcomes associated with them, are highly important ones: to assist victims emotionally, to minimize sexual assault risk to potential victims, to assist incest families with stress coping and to assist victims in coping with the physical trauma. Respondents also reached high consensus that certain objectives were significantly less important: the goal of assisting families and friends of victims; and the outcomes of restoring victims' sense of trust in others, improving incest families' sense of trust, and teaching potential victims self-defense skills. In general, round-to-round changes in judgments showed small but consistent increases across goals in importance ratings.

While the data indicate few areas of uncertainty regarding victim intervention, participants did disagree on value assignments for certain items. Role, setting, and sex differences emerged. Value conflicts were organized around the goals of minimizing risk to potential victims and assisting family and friends of victims, as well as the outcomes of informing educators about identifying high risk families and enforcement of reporting laws. Special consideration issues concerning factors guiding effective treatment, criteria for reporting juvenile sexual assault, and use of male providers in sexual assault treatment and prevention also elicited value disagreements among participants.

With respect to items representing knowledge, skills, and sensitivities needed by service providers in sexual assault intervention, four underlying dimensions were generated: Generic Interview Skills, Intervention Procedures, Effective Knowledge Base, and Identification of Intervention Targets. Within the factors, highest consensus was obtained for items within Generic Interview Skills. For example, 100% of participants endorsed the importance of being able to conduct interviews nonjudgmentally, ethically and responsibly so as to communicate respect and concern and to minimize the chance of further stress.

Three major themes describe special considerations involving victims of sexual assault: responses to inquiries about effective intervention guides suggest that consideration of very individualized needs and abilities of victims is critical for treatment designs with most emphasis given to what is available in conscious awareness; second, concerning issues specific to juvenile victims, a majority of respondents view intervention as necessary and judge the major juvenile treatment obstacles to be limited options for protecting abused children, lack of knowledge about child treatment, and the general vulnerability of children; and third, regarding the value of different kinds of working relationships between mental health and criminal justice systems, consultation provided by mental health practitioners and collaborative training programs received highest priority. Finally, for a difficult set of forced-choice intervention decisions, participants generally agreed on where to focus treatment directions.

Assailant Intervention

TABLE 15
INTERVENTION GOALS FOR ASSAILANTS

Goals in order of importance	Average importance†
**To treat and rehabilitate self- and systems-identified assailants	4.9
**To hold assailants legally accountable for their actions	4.9
*To treat self- and systems-identified potential assailants	4.6

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
†5-point scale of importance, with a mean standard deviation of .60.

The three proposed goals for intervention with assailants are all seen as very important by respondents (see Table 15). Two of the three goals (to treat and rehabilitate assailants, and hold them legally accountable for their actions) attained a high level of consensus about their rated importance as well; ratings of the importance of treating potential assailants were moderately consensual. However, statistically significant differences in judgment emerged when participant subgroups were compared on responses to round 1. The goal of legal accountability elicited role differences, both service providers and researchers rating this goal as less important than those engaged in dual roles ($F = 4.20$, $p < .05$). The goal of treating potential assailants was also differentially evaluated on the basis of respondent roles; in this instance service providers judged the goal more important than any others ($F = 3.45$, $p < .05$). Outcomes related to each of these goals are discussed in order below.

TABLE 16
ASSAILANT OUTCOMES FOR GOAL:
To treat and rehabilitate self- and systems-identified assailants

Outcomes in order of importance	Average importance†
**Assailant uses alternative strategies to acting out sexuality aggressively	4.9
**Assailant relates to women as human beings rather than as objects	4.9
**Assailant has a support system that helps assailant from committing further assaults	4.9
**Assailant has improved skills in how to manage life stress	4.9
*Assailant has a sense of self-worth	4.3
*Assailant has improved skills in communicating with others	4.2
Assailant has personal insight into own internal emotional conflicts	3.6
*Family and friends of assailant understand and cope with the assailant's actions	3.6

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
†5-point scale of importance, with a mean standard deviation of .60.

Table 16 presents information about desired outcomes for the highest ranked goal of treating and rehabilitating assailants. In this outcome set, high importance ratings and high obtained consensus occurred for the four top priority items. The four remaining outcomes all received substantially lower importance ratings. Less valued outcomes generally attained lower levels of participant agreement with one (assailant insight into internal conflicts) failing to achieve even moderate consensus.

These results suggest that with respect to assailant intervention, respondents place a higher priority on changing assailant behavior than on intrapersonal growth. This conclusion, however, is conditioned by differential evaluation of two intrapersonal outcomes on the basis of respondent role. Improved communication skills and insight into internal conflicts were both judged more important by service providers than those in any other role ($F = 3.53$, $p < .05$ and $F = 7.88$, $p < .001$, respectively). It should also be noted that as with victim intervention outcomes (see above), enhanced coping of family/friends is not seen as a high importance item in comparison with items directly involving the intervention target.

TABLE 17
ASSAILANT OUTCOMES FOR GOAL:
To hold assailants legally accountable for their actions

Outcomes in order of importance	Average importance[t]
**Assailants are effectively deterred from committing additional sexual assaults, reducing the repetition of such crimes	5.0
**As many assailants as possible are apprehended and convicted	4.8
**Effective community action strategies bring a greater number of assailants into the criminal justice system	4.8
**Probationary requirements are well adhered to by assailants	4.8
*The assailants who are apprehended and convicted are representative of the larger group of those who are actually committing the crime	4.6
*Assailants are held financially responsible for damages that have been incurred	4.6

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .68.

The goal of holding assailants legally accountable was associated with a set of six highly important outcomes (see Table 17). Among them, the four highest rated outcomes also obtained high levels of consensus. Remaining outcomes obtained moderate consensus with no between participant differences. It would seem that intervention oriented toward achieving legal accountability is an important and well understood goal.

TABLE 18
ASSAILANT OUTCOMES FOR GOAL:
To treat self- and systems-identified potential assailants

Outcomes in order of importance	Average importance[t]
**The potential assailant uses constructive alternative strategies to coping with aggressive and sexual feelings	5.0
**The potential assailant relates to women as human beings rather than as objects	4.9
*All high-risk potential assailants identify themselves and seek help	4.5
*The potential assailant has support system of family and/or friends	4.5
The potential assailant understands his own internal dynamics and emotional conflicts	3.9

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .59.

Treatment of potential assailants, the third ranking goal, was linked with two very important and consensual outcomes, using constructive means of coping with angry or sexual feelings and relating to women as human beings (see Table 18). These results suggest a similar intervention strategy for potential as well as actual assailants--one which focuses on behavior change rather than intrapsychic change. The two outcomes next in priority for intervention with potential assailants are self-identification and help seeking, and development of a support system; these attained only moderate consensus. Substantially less valued than the others, the lowest ranking outcome in this set focused on self-insight for potential assailants; it did not achieve consensus. It seems likely that participants identified as most valued those intrapsychic changes linked to behavioral change for potential assailants.

As before, questions about intervention outcomes are followed by an inquiry into the knowledge, skills, and sensitivities needed by service providers in order to facilitate them. The 15 attributes specified for providers in relation to assailant outcomes were examined in terms of importance and consensus as well as their factorial structure. The factor analytic findings are presented in the right half of Table 19, while standard importance and consensus findings are on the left. About half of the items (the first eight listed) were seen as very

TABLE 19
KNOWLEDGE, SKILLS AND SENSITIVITIES INVOLVED IN ASSAILANT INTERVENTION

Knowledge, Skills, Sensitivities in order of importance	Average importance[t]	Factors I	Factors II	Factors III
**Ability to conduct interviews in an ethical and responsible manner	5.0		.79	.41
**Ability to apply knowledge of assailant psychological and sociological dynamics to treatment with individual assailants	4.9	.75		
**Ability to adjust treatment choice and approach according to the particular psychological problems assailant presents	4.9	.47		.59
**Ability to understand and carry out activities in accordance with the legal and judiciary process	4.8			.85
**Ability to use community resources effectively	4.8		.81	
**Ability to cope with one's own job-related stress and to find effective means of stress reduction	4.8	.54	.60	
**Ability to effectively choose treatment or rehabilitation approach in accordance with the legal requirements and options	4.8			.75
**Ability to identify specific emotional reactions assailants may be experiencing	4.8	.77		
Personal insight into one's own reactions/attitudes towards sexual assault	4.7	.46	.52	
Ability to organize community support for programs aimed at apprehending and deterring assailants	4.6			
Ability to conduct interviews in a nonjudgmental manner	4.6		.45	
Ability to use research and related information to most effectively apprehend and convict	4.3			.63
Ability to provide treatment which takes into account the cultural background of the assailant	4.2		.42	.41
Ability to communicate knowledge regarding interpersonal aspects of human sexuality to assailants	4.1		.46	
Ability to accurately identify potential assailants on the basis of clinical information	3.8	.73		

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .62.

important with a great deal of consensus, these include a range of generic interview standards, treatment specific skills, and effective use of legal and community resource information. Remaining items exhibit descending priority and do not achieve consensus; they are a heterogeneous set ranging from self-insight to insight into the assailant's cultural background, from use of research data to clinical information.

In order to organize these diverse skills, factorial analyses were attempted requesting solutions with three, four, and five factors. The three-factor solution shown in Table 19 seemed capable of providing an adequate and parsimonious underlying structure. The validity of the factors is suggested by their similarity to those obtained for victim intervention skills; they account for 65% of the total response variance. Factor loadings are shown for skill items found to be highly associated ($\geq .40$) with specific factors.

Factor I accounts for the largest proportion of the explained variance (41%) and corresponds to the victim intervention factor labeled INTERVENTION PROCEDURES. High loading items include skills in identification and in individually adapting treatment. The second factor obtained is quite similar to the victim intervention factor called GENERIC INTERVIEW SKILLS, and accounts for 13% of the variance. Ethical interviewing, use of community resources, and coping with job stress are the highest loading items, confirming the notion that interview skills may be attained independently of specific treatment knowledge. Accounting for 11% of the variance, the third factor underlying assailant intervention skills differed somewhat from any of the victim intervention skill factors. It comprised high loading items regarding conformance with legal procedures as well as involving application of knowledge of ethics, research and individualized treatment. It has therefore been identified as describing GENERAL ACCOUNTABILITY of service providers in a range of settings.

As for victim intervention, special considerations were identified for assailant intervention and included at the end of the section (see Appendix A, pp. 22-25). These items are discussed in groups, according to general topics. Several items deal with the nature of sexual assault. For example, one such item (Appendix, p. 23) asked respondents whether they viewed sexual assault as primarily sexual, primarily violent, or both equally. In reply, 65% of participants chose--primarily violent; others were equally divided among remaining alternatives.

TABLE 20
MOTIVATIONS FOR SEXUAL ASSAULT

Motivations in order of importance	Average importance^t
**Need to assert dominance over victim or group of which victim is a member	4.9
**Need to express anger and/or rage toward victim or group of which victim is a member	4.8
*Need to degrade/humiliate victim or group of which victim is a member	4.7
*Need to express violence towards victim or group of which victim is a member	4.5
*Need to assert assailant's sense of himself as a male	4.4
Need to master personal inadequacies	3.7
Need to assert one's sexual virility	2.8
Desire for erotic arousal in suffering of victim	2.5
Desire for sexual satisfaction for assailants	1.9

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
^{t}5-point scale of importance, with a mean standard deviation of .72.

Presumed reasons for sexual assault were assessed by two questions. The first inquired about the importance of 9 hypothesized assailant motives (Appendix A, pp. 22-23). Among them only two items received both high importance ratings that were also highly consensual--to assert dominance and to express anger (as shown in Table 20). The next three motivations--to degrade/humiliate, to express violence, and to assert maleness--while also achieving relatively high importance ratings, were only moderately consensual. Remaining hypothesized motives ranked substantially lower in priority and failed to attain consensus.

Such findings suggest that respondents consistently identify motivation for sexual assault as power or anger related rather than sexual. However, statistically significant differences characterized the viewpoints of role-defined subgroups of participants. The importance of sexual satisfaction as a motive elicited role differences, with researchers rating it higher than either service providers or those engaged in dual roles ($F = 3.53$, $p < .05$). Degradation of victims, in contrast, was judged a more important motive by those engaged in dual roles than by either service providers or researchers ($F = 3.45$, $p < .05$).

The second explanatory series asked respondents to rate presumed causes for sexual assault from a range of nine possible choices. (The results are not tabled here since the conclusions overlap in most respects with conclusions to a similar question reported below in the prevention section.) Causes rated as most important were socialization to male role, internalized sexism, and normal male sexuality--all of which achieved moderate consensus levels. Items in the mid-range of importance, for which consensus was not attained, were personality defects and individual sexual disorder. Interestingly, strong consensus emerged regarding the distinct unimportance of two causes, biochemical disorder and genetic defect. These findings are consistent with others in this section and add the societal dimension to explanations of sexual assault.

Issues in assailant intervention constitute another set of special considerations. One major issue concerned criteria for assailant treatability. Among them three were rated highly important, with high consensus: number of assaults, amount of violence, and assailant motivation. The other three criteria were rated slightly lower in importance, with moderate consensus: assailant personality, assault type, and type of victim. It seems, then, that respondents assess treatability primarily in terms of repetition and severity of assault as well as the purpose it serves for the assailant. Respondents endorsed the use of female service providers for counseling assailants (94% said "yes"), in contrast to findings about use of males for counseling victims.

TABLE 21
OBSTACLES IN TREATMENT OF ASSAILANTS

Obstacles in order of importance	Average importance[t]
**Inadequate treatment methods for assailants	4.9
*Inadequate knowledge concerning assailants	4.7
**Assailants low motivation to change	4.6
**Social structure which supports coercive sexuality	4.6
*Violent orientation of society	4.5
*Difficulty interviewers have in working with assailants because of interviewers' own feelings	3.0

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .71.

Obstacles to assailant treatment provided another issue area for investigation (see Table 21). Here barriers seen as very important were inadequate treatment methods, social support for coercive sexuality, and low motivation. While there was strong consensus about the importance of all three obstacles, the third evoked differences between subgroups. Rape crisis center practitioners rated it a more serious obstacle than participants from any other setting ($F = 4.87$, $p < .05$). Moderately consensual obstacles seen as important were inadequate knowledge about assailants and a violent society. Again, rape crisis center practitioners viewed the latter obstacle as more important than those in other settings ($F = 3.37$, $p < .05$).

Interestingly, the interviewer's own feelings about assailants was consensually regarded as an unimportant obstacle. This judgment is consonant with responses to a similar question in the victim intervention section , where interviewer feelings were consistently seen as obstacles of less importance.

A third set of issues concerned enforcement of sexual assault laws. Respondents were asked to indicate whether or not assailants were all equally likely to be apprehended/convicted; most said "no" (92%). Respondents also consensually endorsed four strategies offered for alleviating enforcement problems, including legal reform of sexual assault definitions (96%), community enforcement research (85%), community review boards of legal systems (83%), and court monitoring (81% endorsement).

In general there were fewer, but more diverse written-in suggestions from participants for open-ended items in the assailant intervention section than were in the victim section. To the list of possible motivations for sexual assault, the assailant's need for power was added by quite a few participants. Several participants also included the acting out of violence or aggression to the list of causes of sexual assault. For improving assailant conviction rates, a number of respondents suggested programs directed at the educational and attitudinal development of potential jurors. And, as an additional obstacle to assailant treatment, some respondents identified lack of social support for a range of activities (identification, prosecution, sentencing) up to and including treatment itself. Finally, out of the many diverse responses to an inquiry about desirable research in assailant intervention, six categories of recommendations emerged. Broadly identified, these called for study of: 1) cultural/societal factors stimulating or maintaining sexual assault; 2) comparison of treatment methods; 3) cure versus deterrance topics; 4) attitudes toward violence and sexuality; 5) sex-related history of assailants; and 6) recidivism.

Assailant Intervention Summary

Participants regard all three assailant intervention goals specified for study as very important. The most valued outcomes associated with them are those that focus on changing assailants' as well as potential assailants' behavior rather than on promoting intrapersonal development. In general, round-to-round changes showed stable progress toward consensus; however, assailant intervention items elicited greater respondent disagreement and uncertainty than did victim intervention items, with less overall concurrence about high and low priorities by the end of questioning. Value disagreements stemmed primarily from role and setting differences. Role differences represented differential evaluation of goals concerned with legal accountability and with treatment of potential assailants, and differential prioritizing of outcomes focusing on assailants' intrapsychic conflicts and motivations. Setting disagreements centered on treatment obstacles (specifically, on the barriers posed by assailants' low motivation and by violence in society).

An examination of knowledge, skills, and sensitivities needed by service providers in assailant intervention yielded three dimensions: Intervention Procedures, Generic Interview Skills, and General Accountability. Here the first two factors are quite similar (although in reverse order) to the first two provider factors in victim intervention. Greatest consensus characterized those provider skills focusing on a range of generic interview standards, treatment specific skills, and effective use of legal and community resource information.

Special considerations were grouped into themes reflecting the nature of sexual assault, assailant intervention issues, and law enforcement. Participants view sexual assault as primarily violent, assailant motives being construed as power- or anger-related rather than as sexual. Major causes for sexual assault were consensually judged to be socialization to male role, internalized sexism, and normal male sexuality; those judged very unimportant were biochemical disorder and genetic defect.

Respondents considered number of assaults, amount of violence, and motivation the primary criteria for assailant treatability. They saw inadequate treatment methods, social support for coercive sexuality, and low motivation as the major obstacles to treatment. Concerning enforcement of sexual assault laws, respondents strongly endorsed strategies such as court monitoring, community enforcement, research community review boards, and reform of legal definitions of sexual assault.

Primary Prevention

The discussion of results in this section focuses on primary prevention; it concerns activities directed toward reducing or eliminating social conditions that increase the likelihood of sexual assault/abuse. Table 22 presents the goals for primary prevention of sexual assault. All three goals--focusing on changing structural features of institutions, people's attitudes, and people's behavior--receive similarly high importance ratings. As the asterisks indicate, there is also a high degree of consensus about each of these goals. Round-to-round changes indicate small but consistent increases in importance ratings for all three goals.

TABLE 22
GOALS RELATED TO PRIMARY PREVENTION OF SEXUAL ASSAULT

Goals in order of importance	Average importance[t]
**To change structural features (policies and practices) of social institutions which support sexual assault/abuse	4.9
**To change people's attitudes/beliefs in order to reduce the incidence of sexual assault/abuse for children and adults	4.8
**To change people's behavior in order to reduce the incidence of sexual assault/abuse for children and adults	4.8

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .51.

There was, however, some participant disagreement about value assignment. Rape crisis center practitioners gave greater importance to the goals of changing structural features of institutions (F=3.70, $p<.05$) and to changing people's behavior (F=5.60, $p<.01$) than did participants from any other setting. Nonetheless, these data suggest that the three primary prevention goals should be considered as interdependent high priority aims.

Since each of these goals is considered equally important, each is discussed in the order it appears on the questionnaire. The first set of outcomes, presented in Table 23, involves changing structural features of institutions which support sexual assault/abuse. These outcomes were generally regarded as very important. Two exceptions (those receiving the lowest ratings) dealt with structural alterations of workplaces; each was rated lower in importance by at least one average standard deviation than higher priority outcomes.

A similar participant agreement pattern emerges, with most items being

TABLE 23
PREVENTION OUTCOMES FOR GOAL:
To change structural feature of social institutions which support sexual assault/abuse

Outcomes in order of importance	Average importance^t
**Family organization ensures that children are not deprived, exploited or oppressed	5.0
**Within family structure, parents raise their children in a manner that promotes development of each child's unique potential regardless of gender	4.9
**Educational institutions provide curricula designed to decrease sex-role stereotyping	4.9
**Educational institutions ensure availability of positive, non-sex-typed role models for children and youth	4.9
**All workplaces ensure that women are not exploited or oppressed	4.8
**Advertising/media organizations ensure that women and men are portrayed as complete human beings	4.8
**Advertising/media organizations communicate an attitude of intolerance toward violence in all programming	4.8
*All workplaces ensure an equitable distribution of women in positions of power and influence	4.6
*Religious institutions promote spiritual equality between women and men	4.3
*All workplaces provide supportive structures (e.g., flexible time and child care arrangements)	3.6
*All workplaces offer viable alternative models to existing hierarchical systems	3.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
^{t}5-point scale of importance, with a mean standard deviation of .64.

highly consensual. In fact, the first outcome--creating family organizations that prevent exploitation and oppression of children--obtained 100% consensus by round three. In contrast, the two outcomes singled out as lowest in importance were the only ones whose importance scores decreased from round-to-round. It is worth noting that the most valued outcomes focus on structural changes in the areas of family, education and advertising/media; the less valued ones focus on major structural modifications of workplaces.

To assess whether relatively low mean value and consensus about workplace items reflected conflicting values among participants, analysis of variance were carried out. The outcome concerned with provision of supportive structures elicited significant disagreement on the basis of both sex and setting. Not surprisingly, females gave it greater importance than did males ($F=10.87$, $p < .01$). Further, rape crisis center practitioners ascribed this outcome significantly greater importance than did participants from any other setting (F= 4.02, p<.05). Lack of consensus about the value of providing supportive workplace structures thus seems to be explained in part by between group differences in viewpoint. However, lack of consensus about offering viable alternative models to existing hierarchical workplace systems appears to represent value uncertainty.

TABLE 24
PREVENTION OUTCOMES FOR GOAL:
To change people's attitudes/beliefs in order to reduce the incidence of sexual assault/abuse for children and adults

Outcomes in order of importance	Average importance[t]
**People have intolerance for any victimization of others	5.0
**People believe in human equality and self-determination	4.9
**People believe that male/female interactions should be based on equality	4.9
**People understand the sociocultural context of sexual assault/abuse	4.8
**People believe that unequal power relationships between males and females contribute to sexual assault and sexual oppression	4.7
**People believe that certain features of institutional structures support unequal power relationships between males and females	4.7
**People believe that particular personality characteristics and social roles should not be assumed to be linked with gender	4.7
**People believe in the value of human life	4.6

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .57.

Outcomes related to the goal of changing attitudes and beliefs to reduce the incidence of sexual assault are uniformly rated as very important by participants (see Table 24) with similarly high levels of consensus. The first outcome--developing intolerance for any victimization of others--obtained 100% consensus by the third round. These data indicate strong participant agreement on the range of attitudes that need to be changed to contribute to primary prevention efforts.

Table 25 presents results for outcomes related to the goal of changing people's behaviors to reduce sexual assault. Items were divided on the basis of sex of target population since the most typically reported sexual assault pattern involves males as assailants and females as victims.

As with psychological change, participants judge behavior change outcomes uniformly as very important. Agreement about most of these outcomes is strong as well, all but two reaching high consensus on the specific importance ratings

TABLE 25
PREVENTION OUTCOMES FOR GOAL:
To change people's behavior in order to reduce the incidence of sexual assault/abuse for children and adults

Outcomes in order of importance	Average importance[t]
FEMALES	
**Females exhibit confidence in their own skills and abilities	4.9
**Female behavior is not dependent upon socially prescribed sex role norms	4.8
**Females exhibit self-reliant behavior and do not need to seek male approval	4.8
**Females act assertively in interactions with other people	4.8
**Females are able to defend themselves physically and psychologically against violence and abuse	4.8
*Females do not engage in coercive sexual behavior	4.5
MALES	
**Males do not engage in any form of coercive sexual behavior	5.0
**Males deal with anger toward others in constructive ways	5.0
**Males exhibit sensitivity to other people's feelings	4.9
**Males respect females as equals	4.9
**Males do not use aggressive violent behavior against others	4.9
**Male behavior is not dependent upon socially prescribed sex role norms	4.8
*Males exhibit cooperative behavior in interactions with others	4.5

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .54.

given. The first two male outcomes--not engaging in any form of coercive behavior and dealing with anger toward others constructively--achieved 100% consensus from participants by Round 3.

The primary prevention portion of the questionnaire differed from preceding parts (see Appendix A) by including after each group of goal-related outcomes an inquiry into effective strategies for actualizing them. The three sets of prevention strategies are discussed in order here.

Strategies related to the goal of changing structural features of social institutions are provided in Table 26. (Please note that mean ratings in prevention strategy tables refer to average effectiveness rather than importance.) The three strategies regarded as most effective involve non-sexist educational efforts, legislative lobbying approaches, and consultation to schools. Remaining lower ranking items concern more politically based strategies such as union organizing, boycotting, political campaigning, and inspection/monitoring of workplaces. All eight items were considered significantly less powerful strategies; their mean effectiveness ratings falling at least a standard deviation below those of the top three items.

TABLE 26
PREVENTION STRATEGIES FOR GOAL:
To change structural features of social institutions which support sexual assault/abuse

Strategies in order of effectiveness	Average Effectiveness[t]
**Education efforts for non-sexist, non-exploitive child rearing	4.9
*Legislative lobbying groups	4.5
*Consultation for curriculum development in schools	4.3
Increased recruitment efforts for women and on-the-job training	4.1
*Conferences focused on sexual assault prevention (local, state, national levels)	3.8
*Public pressure groups (e.g., letterwriting, sexual assault task forces, petitions)	3.8
Community accountability boards/advisory councils to business and government	3.7
*Union organizing groups	3.6
*Boycotting organizations and products	3.4
*Political campaigning for candidates	3.2
*Inspection/monitoring programs of all work places	3.1

**High consensus (consensus=80 percent of respondents in effectiveness rating).
*Consensus (consensus=50 percent of respondents in effectiveness rating).
[t] 5-point scale of effectiveness, with a mean standard deviation of .81.

As with effectiveness ratings, there is considerable variation in degree of consensus associated with these strategies. The majority attain moderate consensus with only the first prevention strategy (educational efforts for non-sexist, non-exploitive child rearing) receiving high consensus. In fact, one item--community accountability board/advisory councils to business and government--failed to attain consensus at all. These data suggest general uncertainty about the value of particular strategies for prevention efforts. Looking back, then, the findings indicate that while outcomes for this goal are generally clear, there appears to be considerable uncertainty about the effectiveness of state-of-the-art strategies for implementing them.

TABLE 27
PREVENTION STRATEGIES FOR GOAL:
To change people's attitudes/beliefs in order to reduce the incidence of sexual assault/abuse for children and adults

Strategies in order of effectiveness	Average effectiveness[t]
**Parent education training	4.8
**Non-sex-role-stereotyped curriculum development in schools	4.8
**Sex role education training for teachers	4.8
*Sexual assault awareness programs	4.6
*Consciousness-raising groups for males and for females	4.5
*Media campaigns	4.5
*Feminist classes and training in non-sex-stereotyped areas	3.8

**High consensus (consensus=80 percent of respondents in effectiveness rating).
*Consensus (consensus=50 percent of respondents in effectiveness rating).
[t] 5-point scale of effectiveness, with a mean standard deviation of .69.

Table 27 presents strategies for changing attitudes and beliefs. The most effective strategies involved educational and training activities aimed at sex role change. These were followed in terms of priority by strategies concerned with changing public opinion through media campaigns, sexual awareness programs, or consciousness-raising groups. The least effective strategy--feminist classes and training in non-sex-stereotyped areas--was rated lower in effectiveness by at least one average standard deviation than the more effective strategies. The three most effective strategies receive high consensus among the participants, while the other four items attain only moderate consensus.

TABLE 28
PREVENTION STRATEGIES FOR GOAL:
To change people's behavior in order to reduce the incidence of sexual assault/abuse for children and adults

Strategies in order of effectiveness	Average effectiveness[t]
**Non-sex-role-stereotyped curriculum development in schools	4.8
**Sex role education training for teachers	4.8
**Parent education training	4.8
*Sexual assault awareness programs	4.8
*Consciousness-raising groups for males and for females	4.5
*Male/female communication training	4.1
*Assertiveness training/classes for males and females	3.9
*Feminist classes and training in non-sex-stereotyped areas	3.7
Self-defense classes for females	3.6

**High consensus (consensus=80 percent of respondents in effectiveness rating).
*Consensus (consensus=50 percent of respondents in effectiveness rating).
[t] 5-point scale of effectiveness, with a mean standard deviation of .68.

The last set of prevention strategies concern changing behavior (see Table 28). Items focusing on educational and training activities toward sex role re-socialization receive equivalent high effectiveness ratings. Strategies concerned with more political and feminist consciousness-raising efforts receive significantly lower ratings; they rate lower in effectiveness by at least one average standard deviation from the top three strategies. Interestingly, the strategy regarded as least effective by participants is one which is a very widespread practice--self-defense classes for females. (As indicated above, this practice also receives lowest priority in the victim section dealing with individual prevention approaches.) With regard to consensus, a similar pattern emerged. The top three strategies obtain high consensus, while the more political strategies receive only moderate consensus and the self-defense strategy failed to attain any consensus.

To produce a clearer organization of primary prevention efforts, 27 prevention strategies were subjected to factor analysis. Since social change strategies are often the same regardless of specific targets, strategies were combined from the three primary prevention goals for analysis purposes. Solutions were requested using four, five, and six factors; results indicated that a five-factor solution most adequately and parsimoniously accounted for response variation (70% of variance was accounted for). Table 29 lists the three sets of primary prevention items on the left. Factor identifications appear as column headings to the right, with

TABLE 29
FACTOR STRUCTURES OF PREVENTION STRATEGIES

	Factors				
Prevention Strategies	I	II	III	IV	V
Goal 1					
Public pressure groups (e.g., letterwriting, sexual assault task forces, petitions)		.43			.54
Union organizing groups	.55	.51			
Boycotting organizations and products		.56	.42		
Political campaigning for candidates		.78			
Community accountability boards/advisory councils to business and government		.89			
Conferences focused on sexual assault prevention (local, state, national levels)		.48			
Consultation for curriculum development in schools		.45		.50	
Inspection/monitoring programs of all workplaces		.63	.45		
Increased recruitment efforts for women and on-the-job training	.44	.49			
Education efforts for non-sexist, non-exploitive child rearing		.46		.46	
Legislative lobbying groups		.48			.41
Goal 2					
Assertiveness training/classes for males and females				.40	
Consciousness-raising groups for males and for females				.78	
Male/female communication training	.64			.42	
Self-defense classes for females			.65		
Feminist classes and training in non-sex-stereotyped areas			.75		
Sexual assault awareness programs					.70
Parent education training	.69				
Non-sex-role-stereotyped curriculum development in schools	.75				
Sex role education training for teachers	.74				
Goal 3					
Parent education training	.62				
Consciousness-raising groups for males and for females				.83	
Non-sex-role-stereotyped curriculum development in schools	.76				
Sex role education training for teachers	.75				
Media campaigns					.43
Sexual assault awareness programs					.89
Feminist classes and training in non-sex-stereotyped areas			.71		

the loading of each item ($\geq$ .40) in the appropriate column. Social change efforts involve both the systemic and individual levels.

The factor which accounts for the largest proportion of the variance (37%) we have called GENERIC SEX ROLE CHANGE. This first factor is defined by socialization strategies having to do with sex role education training for teachers, development of non-sex-role-stereotyped curriculum in schools, and parent education training. These together with the other items loading on the factor, support the interpretation of the underlying dimension as representing long-term systemic educational and training activities aimed at parents, teachers, and children for the purpose of more egalitarian sex role socialization.

The second factor, accounting for 11% of the variance, is termed STRUCTURAL/POLITICAL CHANGE because it includes all of the prevention strategies associated with institutional modifications in all systems which support sexual assault. This factor is characterized by strategies involving political campaigning, establishing community accountability boards or advisory councils to business and government, and setting up inspection and monitoring programs in all workplaces. It concerns longer-term structural alterations of basic societal systems.

The next two factors highlight prevention strategies with individuals which could be undertaken on a shorter-term basis. Factor III is labeled BEHAVIOR CHANGE and accounts for about 8% of the variance. Direct behavior changes such as self-defense classes for females and feminist training in non-sex-stereotyped areas typify this factor. Factor IV, called ATTITUDINAL CHANGE, accounts for slightly over 7% of the variance and parallels the individual change efforts of Factor III. This factor is distinguished by consciousness-raising groups for males and females as a vehicle for implementing sex role attitudinal changes.

The last factor, CHANGING PUBLIC OPINION, accounts for the smallest share of the variance (7%). The item loading most strongly on this factor--sexual assault awareness programs--aims at intervening en masse through public media to increase general awareness and thereby effect sex role change.

Ten items comprise the portion concerned with knowledge, skills, and sensitivities needed by service providers in prevention of sexual assault. As Table 30 indicates, participants regarded these social action-oriented skills as very important. One exception--mastery of group process skills--received an importance rating that was more than one standard deviation away from the score of the adjacent item in the table. Further, a high level of consensus characterized over half the

TABLE 30
KNOWLEDGE, SKILLS AND SENSITIVITIES INVOLVED IN PRIMARY PREVENTION

Knowledge, Skills, Sensitivities in order of importance	Average importance[t]
**Ability to communicate ideas clearly and persuasively	5.0
**Ability to use community resources effectively	5.0
**Ability to apply knowledge of sociocultural dynamics of sexual assault to prevention	4.9
**Ability to apply knowledge of relationship between socialization practices and sexual assault	4.9
**Ability to mobilize diverse groups of people	4.9
**Sensitivity to alternative values/orientation of different social systems and groups of people	4.9
*Ability to apply knowledge of inequities in power relationships between males and females to prevention	4.7
*Personal insight into own attitudes/reactions to sexual assault	4.7
*Ability to apply learning principles to prevention efforts	4.6
*Mastery of group process skills	4.2

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
[t] 5-point scale of importance, with a mean standard deviation of .41.

responses. The first two abilities--to communicate ideas clearly and persuasively, and to use community resources effectively--elicited 100% consensus by round three. The last four skill items, in contrast, received ratings that were moderately consensual.

Special considerations related to primary prevention addressed three broad concerns: fundamental causes of sexual assault, decisions about targeting prevention efforts, and community education strategies. Data from special consideration items will be discussed in terms of these three groupings in order (see Appendix A, pp. 34-37).

Table 31 summarizes judgments about possible primary causes of sexual assault. As the table shows, the participants reached high agreement both on causes they regarded as very important and on those they considered unimportant. The top three causes, involving social structural explanations, were uniformly judged very important. In contrast, the last six items--related to recent social changes in women's role and to sexual aggressive drives--received uniformly low importance ratings. In fact, the last eight causes were all considered significantly less important, their average importance ratings falling at least a standard deviation below those of more salient causes. It is interesting to note that these lower ranking items were the only ones in the set whose importance scores decreased from round to round.

TABLE 31
FUNDAMENTAL CAUSES OF SEXUAL ASSAULT

Causes in order of importance	Average importance^t	Factors		
		I	II	III
**High prevalence of violence in society	4.8			
**Social conventions perpetuating sexism	4.7	.75		
**Social structure which promotes power discrepancies between males and females	4.6	.90		
*Economic structure supporting female dependence on males	3.8	.69		
Social conventions perpetuating racism	3.2	.74		
*Breakdown of nuclear family structure	1.5	-.40	.44	
*Female's changing social role from domestic sphere to public sphere	1.4		.69	
*Biological aggressive drives	1.3			.72
**Natural sexual instincts	1.2			.74
**Female style as enticing	1.2			.59
**Blurring of roles between male and female	1.1		.94	

**High consensus (consensus=80 percent of respondents in importance rating).
*Consensus (consensus=50 percent of respondents in importance rating).
^{t}5-point scale of importance, with a mean standard deviation of .70.

The participant agreement pattern reflects high consensus about those items which represent fundamental causes as well as those which do not. That is, high rates of agreement emerge for the top three causes and for the bottom three causes in the set. Items of intermediate importance receive only moderate consensus, with social conventions perpetuating racism failing to attain any causal consensus.

Examining these items in a factor analysis confirmed the dimensional structure suggested by the importance ratings. A three-factor solution accounted for 67% of the variance. The factor explaining the largest proportion of the variance (32%) represented causes involving social structures that perpetuate oppression and aggression. The next factor (accounting for 24% of the variance) included causes concerned with recent social changes in the female role. The last factor (accounting for 11% of the variance) involved items related to sexual aggressive drives and instincts.

To determine the extent of acceptance of the causal structure among participants, analyses of variance were carried out. Causes focusing on social structural explanations elicited significant disagreement on the basis of both sex and setting. In the case of sex, female participants ascribed significantly greater causal importance than males did to social structures that promote power discrepancies between men and women ($F = 11.74$, $p < .01$); to social conventions perpetuating sexism ($F = 6.53$, $p < .01$); and social conventions perpetuating racism ($F = 4.54$, $p < .01$). With respect to setting, rape crisis center practitioners judged the same three causes to be more important than participants from any other settings ($F = 4.08$, $p < .05$). Causes citing changed female roles and biological instincts also elicited differences based on sex. Male respondents judged the breakdown of the nuclear family ($F = 4.71$, $p < .01$) and biological aggressive drives ($F = 6.40$, $p < .05$) as significantly more important causes of sexual assault than female respondents.

Several questions addressed the issue of where primary prevention emphasis should be placed. At the broadest level, participants were asked to prioritize overall sexual assault intervention and prevention efforts. Responses indicated a fairly equal allocation of effort for victim and assailant intervention and primary prevention. Specifically, 40% of effort was suggested for allocation to victim treatment (divided evenly between adult and child victims); 31% for allocation to primary prevention; and 28% to intervention with assailants (divided evenly between treatment and legal accountability efforts). Specific institutions cited as main targets for primary prevention activity are education (47%), families (41%) and advertising/media (10%). These institutions are the same ones that participants rated as highly important foci in effecting structural changes to prevent sexual assault.

Individuals regarded by participants as major targets of primary prevention efforts are early adolescents (37%), the general public (31%), and elementary age children (18%); adult women (3%) and adult men (1%), in contrast, were not high priority targets. However, when asked to judge which segments of the population are at highest risk for being sexually assaulted/abused, 100% of the respondents designated both early and late adolescents as particularly vulnerable. Also considered at high risk were adult women (96%) and elementary age children (90%). A somewhat smaller proportion of participants regarded lower socioeconomic groups (86%), young children (82%), disabled people (82%), non-Caucasian groups (80%), and elderly people (74%) as high risk groups.

The last set of priority questions focused on the feasibility of primary prevention, i.e., whether individuals or institutions can be motivated to change if they are not reacting to a stressful situation. Ninety percent of the participants responded to this question affirmatively. Further, 94% of respondents recommended using collective rather than individual action to minimize the risk of sexual assault. There was also strong agreement (92%) that members of the public should undertake action strategies to hold assailants accountable to the community for their actions.

Finally, a set of community education questions examined the utility and effectiveness of specific approaches and programs dealing with sexual assault prevention. To present the issue of susceptibility to sexual assault, 88% of participants support the strategy of raising audience anxiety by indicating that sexual assault can and does happen to anyone, anytime, anywhere. With respect to presenting the severity of sexual assault, 100% of participants support emphasizing that it is an emotionally traumatic experience which can have serious consequences but from which victims do recover and may even be emotionally stronger as a result. Examination of these issues in terms of participant variables yielded both sex and role differences. Concerning one strategy, 82% of the females endorsed raising audience anxiety, in contrast to only 25% of the males ($F = 13.42$, $p < .001$). Those engaged in dual roles also saw the increased anxiety strategy as more effective than either practitioners or researchers viewed it ($F = 10.22$, $p < .05$).

There was a great deal of diversity among written-in responses to open-ended primary prevention questions. Only the most consensual are mentioned here. For instance, an additional strategy frequently proposed for achieving the goal of changing structural institutions was consciousness-raising and attitude change for men; while an additional strategy for changing attitudes focused on having egalitarian relationships between people. Addressing the fundamental causes of sexual assault, many fill-in responses concerned sex-role stereotyping; participants also identified as causal social attitudes linking sex and violence. Finally, respondents suggested a wide variety of strategies for motivating attitudinal change in a resisting individual or institution, ranging from presentation of sexual assault case histories to educating about the societal scope of the problem.

Primary Prevention Summary

Participants reach strong consensus in viewing the three primary prevention goals as interdependent high priority aims with clear outcomes. With respect to effective strategies for actualizing these objectives, however, much less agreement was in evidence. The data suggest general uncertainty about the value of particular strategies for prevention efforts. Educational and training activities aimed at sex role change were regarded as the most effective approaches, while strategies concerned with more political or feminist consciousness-raising efforts were considered less powerful. Value conflicts stemming from setting and sex centered on the goals of changing institutional structures and people's behaviors, as well as on the strategy of providing supportive structures in workplaces. In general, round-to-round changes in judgments showed small but consistent consensual increases in importance.

When the sets of social change strategies were factor analyzed across goals, five factors resulted: Generic Sex Role Change, Structural/Political Change, Behavior Change, Attitudinal Change, and Changing Public Opinion. Participants apparently regarded the set of social action-oriented knowledge, skills, and sensitivities as all very important (except for mastery of group process skills).

Special considerations related to primary prevention addressed three broad concerns: fundamental causes of sexual assault, decisions about targeting prevention efforts, and community education strategies. Participants reached high agreement about primary causes of sexual assault (social structures that perpetuate oppression and aggression) and about hypothesized causes which they viewed as very unimportant (aggressive drives and instincts, and recent changes in female role). Specified as first targets for primary prevention efforts were educational institutions, families, early adolescents, and the general public. There was unanimous participant agreement that early and late adolescents were particularly vulnerable to sexual assault, with adult women and elementary age children also considered at high risk. Participants also agreed on the utility and effectiveness of specific community education approaches directed to susceptibility and severity for dealing with sexual assault prevention.

Special consideration issues concerning fundamental causes of sexual assault (ranging from social structural causes to recent changes in female role to biological instinctual explanations) as well as effectiveness of community education strategies elicited some value differences among participants based on sex and setting.

Definitions and Concepts

The last set of results presented here comprises participant judgments about appropriate definitions and labels for concepts related to sexual assault. Before reporting them, we should note that these results may have been influenced in part by terms used in preceding portions of the questionnaire. However, we believed these judgments were best made last, after respondents had been thinking about the issues for some time. To elicit judgments about appropriate labels, major sexual assault concepts were defined and a list of possible labels for designating the concepts was provided (see Appendix A, pp. 38-40). A "yes" response indicated the label was considered one of the very best terms (i.e., actively preferred); a "no" meant that it should definitely not be used (i.e., actively rejected). Since respondents did not have to answer either yes or no for each label, percentages cited below do not necessarily reflect the entire sample.

For labeling the concept of an act in which someone has been forced to engage in some kind of sexual activity, the term "sexual assault" was clearly preferred; 98% of participants chose a yes response. Others preferred by a sizeable proportion of participants were "sexual coercion" (87%) and "sexual abuse" (82%). In sharp contrast, the least preferred term was "molestation"; 98% of participants actively rejected it. Other terms considered undesirable by a goodly number of respondents included "sexual violation" (82%) and "victimization" (75%). It is interesting to note that the label "rape" itself received a highly ambivalent response (45% yes, 55% no). These data suggest that participants prefer a label for this concept that connotes a broader interpretation ("sexual assault") rather than a more narrow but perhaps more common one ("rape").

To refer to a person who forces another to engage in some kind of sexual activity, 98% of participants actively preferred the label "assailant." Other approved labels included "sex offender" (79%), "rapist" (73%), and "offender" (67%). For this concept, however, the participants consensually found many more terms to be distinctly undesirable including "violator" (97%), "molester" (95%), "coercer" (93%), "victimizer" (92%), "sexual exploiter" (87%), "perpetrator" (86%), and "abuser" (77%). The participants, then, clearly agree about what assailants should not be called. High consensus was also attained for terms designating a person who has been forced to engage in some kind of sexual activity. Ninety-four percent of participants endorsed the label "victim"; in contrast 79% indicated the term "survivor" should definitely not be used.

The last referential inquiry sought a term for referring to the entire group of Asian/Pacific, Black, Hispanic, Native American, and Arab people. The only actively preferred label was "Ethnic minorities" (93%). In contrast, several labels were actively rejected; "non-Caucasian people" (97%), "Non-Whites" (97%), "Special populations" (94%), "Third World persons" (87%), and "People of color" (84%). It should be noted that in view of the ethnicity of the sample (see Table 2), these results do not necessarily reflect the preference of groups to be designated by suggested labels.

The next set of questions involved definitions of concepts (see Appendix A, pp. 40-41). Participants were provided with a list of possible definitions for sexual assault and incest. We requested two kinds of judgments about them--their quality or desirability per se, and their practicality in common use as a day-to-day operating definition. Our aim was to preserve this theoretical distinction, but we cannot be sure that judgments of practicality and quality are in fact independent. In any case, of the five definitions listed for sexual assault, the simple definition "forced sexual activity" was regarded by 80% of respondents as the best in both quality and practicality. None of the others, including the legal definition, were regarded as qualitatively desirable or even very practical. Most importantly, the legal definition was consensually agreed (85%) not to be practical.

Analysis of variance yielded no participant differences concerning quality of any proposed definitions, but revealed participant disagreements about practicality. Practitioners regarded the definition "any forced sexual activity" as more practical than participants in any other role ($F = 4.41$, $p < .05$). Further, rape crisis practitioners ascribed a higher practicality rating to this definition than participants from any other setting. In addition, the more extended definition, "a violent act in which a person or group forces another person under threat of physical or emotional harm or deception to engage in sexual activity," received greater practicality ratings from Regional than National respondents ($F = 4.76$, $p < .05$).

Five possible definitions of incest were provided next (see Appendix A, p. 41). For this concept, 86% of participants ascribed highest quality and practicality to the definition "sexual activity brought about by coercing, manipulating, or deceiving a relative or dependent, other than a spouse." No other suggested definition, including the legal definition, was considered either very practical or desirable. Two definitions elicited significant disagreement about practicality among participants on the basis of sex, setting, and role. For the definition regarded overall as best (see above), female participants judged it more practical than male respondents ($F = 5.31$, $p < .05$). In addition, practitioners attributed to this same definition significantly greater practicality than those in any other role

($F = 3.80$, $p < .05$). On the other hand, participants from criminal justice, medical and social service settings regarded the legal definition of incest as more practical than did mental health or rape crisis center practitioners ($F = 3.45$, $p < .05$).

The last set of Questionnaire items sought to arrive at consensus on how best to build an explanatory structure for sexual assault and incest, or to determine where to bound the interpretation of these concepts (see Appendix A, pp. 42-44). We assumed that three dimensions needed to be taken into account in explaining the nature of either sexual assault or incest: the relationship between assailant and victim, the range of sexual activity involved, and the degree of coercion.

TABLE 32
STRUCTURE OF SEXUAL ASSAULT: PERCENT OF RESPONDENTS CHOOSING EACH BOUNDARY LEVEL FOR THREE CONCEPTUAL DIMENSIONS

DIMENSION I: Relationship to Victim		DIMENSION II: Range of Sexual Activity		DIMENSION III: Degree of Coercion	
stranger	2	vaginal intercourse	0	inability to consent	0
acquaintance	0	anal intercourse	0	physical harm/injury	0
friend	0	oral-genital contact	0	a threat of death	0
lover	0	masturbation	0	a threat of physical harm or injury	2
relative by blood, marriage or adoption	98	genital fondling	12	deception or fraud	0
		display of genitals in a sexual context without contact	69	a threat of significant emotional loss or harm	2
		overtly expressed sexual interest on a verbal level	19	a threat of significant tangible loss	4
				implied threat (non-verbalized, but perceived	55
				promised emotional or tangible rewards	37

Table 32 presents responses related to the nature of sexual assault. It should be noted that items are ordered from narrow and restrictive ones at the top of each list to broad and liberal ones at the bottom. (We assumed that choosing any item would implicitly include all those above it.) Ninety-eight percent of the respondents chose the broadest boundary level for the dimension of relationship to victim, indicating that the conception of sexual assault does not revolve around the victim-assailant relationship. For the dimension of range of sexual activity, 69% of respondents chose to bound the concept with display of genitals in a sexual context, without contact. This judgment suggests that sexual assault may be said to occur in some cases without physical contact. Finally, with respect to degree of coercion, 55% of participants include implied threat (not verbalized, but perceived) as part of the dimension, while 37% of respondents extend the notion of coercion to include promised emotional or tangible rewards.

TABLE 33
STRUCTURE OF INCEST: PERCENT OF RESPONDENTS
CHOOSING EACH BOUNDARY LEVEL FOR THREE CONCEPTUAL DIMENSIONS

DIMENSION I: Relationship to Victim		DIMENSION II: Range of Sexual Activity		DIMENSION III: Degree of Coercion	
parent or sibling	0	vaginal intercourse	0	inability to consent	0
any blood relative	0	anal intercourse	0	physical harm/injury	0
any relative by blood or marriage	0	oral-genital contact	0	a threat of death	0
any relative by blood, marriage, or adoption	2	masturbation	0	a threat of physical harm or injury	0
any relative by blood, marriage, adoption, or any person in the parent or guardian role	98	genital fondling	8	deception or fraud	0
		display of genitals in a sexual context without contact	12	a threat of significant emotional loss/harm	2
		overtly expressed sexual interest on a verbal level	80	a threat of significant tangible loss	0
				implied threat (non-verbalized, but perceived)	2
				promised emotional or tangible rewards	96

Table 33 shows similar results for the nature of incest. Here, too, 98% of participants chose the broadest boundary level for specifying possible relationships of assailant to victim. Eighty percent of respondents also chose the broadest boundary level for describing the range of sexual activity, not requiring physical contact and extending it to include verbal expression of sexual interest. In a similar fashion, 96% of participants selected the most liberal interpretation of degree of coercion (promise of reward) to describe the structure of incest. With respect to developing the concept of incest, only one participant disagreement emerged. With respect to range of activity construed as incestual, female participants typically included display of genitals in a sexual context without contact; male respondents tended to bound the dimension more restrictively at the level of genital fondling ($F = 6.47$, $p < .05$).

There are virtually no write-in responses to report here due to the lack of consensuality of respondent responses.

Definitions and Concepts Summary

Inquiries in this section were divided into three areas: labels, definitions, and bounding sexual assault concepts. Concerning appropriate labels, respondents were asked to name acts in which someone has been forced to engage in some kind of sexual activity; for this usage the term "sexual assault" was clearly preferred. The label "rape" itself received a highly ambivalent response (45% yes, 55% no). To refer to a person who forces another to engage in some kind of sexual activity, participants actively preferred the label "assailant," rejecting most of the other terms offered. The term "victim" was definitely preferred to designate a person who has been forced to engage in some kind of sexual activity. Only the phrase "Ethnic minorities" was approved for referring to the group constituted by Asian/Pacific, Black, Hispanic, Native American and Arab people.

Inquiries about sexual assault and incest considered both the quality and the practicality of the definitions. For sexual assault, the definition "forced sexual activity" was regarded by participants as the best in both quality and practicality. For incest, respondents ascribed highest quality and practicality to the definition "sexual activity brought about by coercing, manipulating, or deceiving a relative or dependent, other than a spouse." In both instances, the legal definitions were not considered either qualitatively desirable or even very practical.

The last set of items attempted to build an explanatory structure for sexual assault and incest. Determination of where to bound the interpretation of these concepts focused on three dimensions: the relationship between assailant and victim, the range of sexual activity involved, and the degree of coercion. For the nature of sexual assault, respondents chose the broadest boundary level for the dimension of relationship to victim (relationship is definitionally excluded). They chose to bound the activity dimension at display of genitals in a sexual context, without physical contact. With respect to degree of coercion, the majority selected implied threat (non-verbalized, but perceived) as the limiting case. For incest, respondents likewise chose the broadest boundary levels for specifying possible relationships of assailants to victims. Similarly, they selected the broadest boundaries for range of sexual activity (verbally expressed sexual interest) and for degree of coercion (promised rewards).

Sexual assault labels, definitions and concepts elicited very few value disagreements among respondents. Value conflicts were obtained for a small number of practicality judgments regarding definitions of sexual assault and incest, as well for defining the limits on the range of activities included in the concept of incest. Generally, round-to-round changes in this section showed stable progression toward consensus.

CHAPTER 4: IMPLICATIONS

As the Rationale Chapter underscores, the 1980's present evidence of a need to stand back and assess the extent to which consensus prevails among knowledgeable workers in the relatively new and rapidly growing fields of rape prevention and rape treatment/intervention regarding underlying causes of sexual assault, intervention approaches for victims and assailants, standards and criteria for practice with these individuals, and primary prevention strategies. Data from the Delphi Study allow us to look at areas where there is agreement, where there is conflict, and where there is uncertainty. In general, the results appear to indicate that there is the greatest agreement with regard to victim intervention, less agreement regarding assailant intervention, and greatest uncertainty regarding primary prevention. Fortunately, definitions and concepts in the field are highly consensual. This chapter addresses the implications of study results under the following categories: Interventions; Prevention; Training; Research; and Policy. Each is discussed separately, although the implications are in many instances interdependent.

Interventions

The term "intervention," rather than "treatment" is used throughout since it encompasses a broader range of activities. Such inclusiveness is particularly appropriate in the case of assailant interventions, where both treatment activities and activities to hold the assailant legally accountable are intended by the term. In addition, those activities considered within the category of secondary prevention (early case-finding, identification) are also included under interventions.

Victims. In the area of victim interventions (both adult and child), four goals reached high consensus and high importance. These goals relate to assisting victims, including incest families, in coping with the emotional impact and physical trauma of the sexual assault. In addition, one of the four involves minimizing risk of sexual assault to potential victims. While none of the remaining goals was judged unimportant, these ratings establish a priority ordering helpful in planning interventions. Service providers could focus upon these priority aims in order to provide effective intervention for any given victim. In addition, because no one agency typically provides all of these priority goals, there is need for more effective collaboration among agencies. The central intervention focus agreed upon by knowledgeable workers in the field, then, is one of assisting victims with the emotional and physical trauma. Since in the case of incest the family can be considered the "victim" on a broader scale, assisting such families became an important goal. However, assisting family and friends when these groups are less directly involved is generally seen as less important.

With regard to specific outcomes for assisting victims in coping with the emotional impact, high importance is consensually given to restoring sense of self-worth, feeling understood and believed, understanding emotional reactions and having support systems. These outcomes can become part of the treatment plan. The outcome which received the lowest importance rating is that of restoring the victim's sense of trust in others. A similar outcome involving incest families (family has an improved sense of trust among its members) attained a similarly low rating. It appeared from the ratings and from written comments that participants may believe restoration of trust should depend on whether or not the environment/family is indeed trustworthy. Trust however should not be taken as an independently desirable outcome. Since restoring trust has generally been agreed upon as an important outcome of treatment, there appears to be a need to establish interventions which focus on the environment and the individual simultaneously in formulating a treatment approach with sexual assault victims. Both internal and external aspects of trust need to be dealt with; the internal aspects would be concerned with the restoration of the adult's or child's ability to trust others/environment, while the external issue would be the actual trustworthiness of the individual's environment. In the case of a child victim, it may be important that there is effective collaboration between treatment agency and protective services in order to address both aspects.

Inspection of highly consensual and very important outcomes for the goal of assisting victims in coping with physical trauma primarily revealed a sensitivity to the emotional impact of the physical trauma. Those items include information about medical procedures, emotional support services, feeling understood and believed by medical service providers, and maintenance of confidentiality. These items could be used for developing a more effective medical protocol for work with victims.

Responses to outcomes associated with the goal of minimizing sexual assault risk to potential victims exhibit variation in degree of consensus and importance. The five high priority outcomes have to do with reducing the incidence of sexual assault primarily through environmental and safety factors. The lower rated outcomes are concerned with identification and training of potential victims in self-defense and other protective skills. The issue of identification of high risk individuals appears to be a controversial one. This may reflect both difficulty in assessing who are the groups at highest risk (when potentially every one is a victim) and confusion about what will happen to these individuals if and when they are identified. In addition, the self-defense training issue is a noteworthy one. Participants are not in agreement about the value of this outcome, and its average importance is relatively low. Given the state-of-the-art now, in which self-defense training is quite frequently implemented, these results require careful study. Some clues to their interpretation can be found in participant responses in the Primary Prevention Section. Under primary prevention strategies, participants rated self-defense classes as the least effective for changing behaviors. In addition, 94% of the respondents recommended collective action (e.g., tenant organizing) rather than individual action (self-defense training) to minimize the risk of sexual assault. However, respondents also saw women acting assertively as an important outcome for primary prevention. Perhaps for longer term prevention and individual intervention, there is a need to expand the definition of "self-defense" to include training in environmental safety measures, individual assertive action, and collective organizing efforts.

The Results Chapter grouped special considerations involving victims of sexual assault in terms of three major themes--(1) factors guiding effective treatment, (2) issues specific to intervention with juvenile victims, and (3) working relationships between mental health and criminal justice systems.

With regard to factors guiding effective treatment, respondents think such interventions are guided by consideration of individualized needs and abilities of victims, with emphasis on what is available to conscious awareness. These judgments appear to be consistent with an individual crisis intervention strategy, rather than a generic crisis approach. The individual crisis approach places more emphasis on the meaning of the event to the individual, the preexisting coping, and cognitive understanding.

The roles of unconscious processes, generic trauma features, and phases of victims reactions in treatment design are important to examine. Service providers regarded unconscious processes as more effective guides than did researchers or dual role personnel. Thus, the lower rating for unconscious factors may reflect a "highly specialized" view of this factor by nonpractitioners.

The difference may also reflect front-line, non-mental-health crisis demands in contrast to longer-term treatment issues, and/or conflicting attitudes within different service sectors regarding the use of unconscious processes. In the latter case, respondents may feel more comfortable focusing upon what support the victim needs at the moment than investigating what unconscious factors may be operating, in order to eliminate any possibility of "blaming the victim." However, generic features and phases of victims' reactions--two guides discussed extensively in the treatment literature--are also rated quite low. Low ratings thus may reflect less certainty about the value of these two aspects at the present. It would appear that additional research is needed to assess the usefulness of these specific factors in guiding treatment and that additional training may be needed in order to assist practitioners in understanding and utilizing them.

In addition, the factors in this questionnaire section, as prioritized by participants, could be used to define an initial assessment interview. That is, initial assessment could be designed to follow the specific items, with each item yielding a different scaled rating. The practitioner would assess each factor according to the following plan:

(1) Victim's responses to assault
    --frantic overreactivity to withdrawal
    --attribution of causality
    --changes life style–minimally to completely

(2) Victim's ability to adapt to stress
    --previous coping strategies--adaptive vs. maladaptive
    --social supports available

(3) Individual aspects of trauma associated with sexual assault
    --degree of force/violence
    --amount of loss associated with trauma
    --single vs. multiple assailants

(4) Relationship of victim to assailant
    --degree of relationship from stranger to relative

(5) Conscious processes of victim
    --conscious aversion of thoughts about event
    --repetitive thoughts and behaviors
    --anger toward assailant

(6) Developmental life stage of victim
    --life stage from child to elderly

(7) Duration of assaultive relationship
    --duration–from single episode to longstanding relationship

(8) Victim's cultural background
    --meaning of event in particular culture
    --utilization of resources

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(9) Victim's family's ability to adapt to stress
--family coping strategies from adaptive to maladaptive

(10) Phases of victim's reactions
--specific phase from outcry, to denial through working through

(11) Generic features of trauma reactions
--specific reactions including anxiety, depression, guilt, shame, anger

(12) Unconscious processes of victim
--self-destructive behaviors
--guilt

This assessment could ennoble better assessment of magnitude of crisis and, therefore, help define treatment strategies to be used. Each of these factors needs to be studied separately and in interactions.

For designing intervention, participants also give greater importance to the needs of victims than to those of victims' families and friends. While this is not a surprising finding, it appears that intervention involving family and friends is a useful strategy for assisting victims, but not important as a goal, outcome or factor guiding intervention.

Regarding juvenile victims, the majority of respondents see intervention as required for recovery from trauma (in contrast to the more mixed response for the necessity of intervention for adults). Thus it may be important for treatment programs to allocate more of their scarce resources to treatment of child victims. More serious obstacles to treatment of juvenile victims were construed in terms of limited options for protecting abused children, lack of knowledge about child treatment, general vulnerability of children, and socialization processes which make children vulnerable. It would appear that there is need for further research and demonstration projects concerning treatment strategies and alternative protective strategies for children. Intervention plans should anticipate and plan for these kinds of obstacles. In addition, training programs for practitioners need to address these issues.

In addition, respondents judged the most important criteria for reporting to be legal requirements and social supports available to the child. It appears that there is uncertainty about the value of reporting and there may be a need for additional training with regard to the use of the report as part of the intervention rather than as a factor running counter to effective intervention.

In forced-choice questions concerned with incest victims, respondents supported reporting in the case of long-term father-son abuse, even though the boy denied his initial disclosure because of fear of impact and the majority of respondents (78%) approved arranging for the father to leave the home, rather than other living arrangements (vis. removing the boy or not changing the living arrangements). Thus, respondents endorsed removing the abuser rather than the child, a change from a current prevalent practice. This issue is part of the more general one of developing alternative "creative" protective strategies.

Finally, an issue under the forced-choice questions should be addressed. When asked about what to deal with first in a hitchhiking situation when the victim raises the issue of "self-destructive behavior," respondents almost equally divided their answers between assuring victim she was not responsible (41%) and exploring decision points to determine whether she had made self-destructive choices (59%). It appears that respondents may not be certain whether exploring guilt feelings will lead to "victim blame" and that we still do not have appropriate strategies or adequate knowledge in dealing with this issue. Further research and training are needed to address this issue in the near future.

With regard to methods for achieving the aims under the victim section, respondents endorsed a number of techniques (see Appendix B). While these findings from Round 1 were not subjected to further ratings and analyses, preliminary tabulations do show consistency and should be studied further. For the top priority goals, respondents checked the following methods with highest frequency: (1) To assist victims in coping with emotional impact, crisis intervention and individual therapy were most frequently checked; (2) To minimize the risk to potential victims, sexual assault awareness programs, public education (of nature, scope and severity of sexual assault), and high risk victim identification programs were most frequently checked; (3) To assist incest families in coping with emotional impact, crisis intervention and community programs were most frequent; (4) to assist victims in coping with physical trauma, emergency sexual assault medical intervention teams was most frequent.

Assailants. With regard to assailant interventions, the three proposed goals for intervention were all seen as very important. Two of the goals--treating and rehabilitating assailants and holding assailants legally accountable for their actions--also attain high consensus. There was less consensus on treating potential assailants. For treatment and rehabilitation, respondents place higher priority on changing assailant behavior than on intrapersonal growth. In addition, as with victim intervention, enhanced coping of families/friends is not seen as a high importance outcome. For the goal of holding assailants legally accountable, six highly important outcomes were obtained.

The four also obtaining high consensus were assailants are effectively deterred from committing further assaults, as many assailants as possible are apprehended and convicted, effective community action strategies bring a greater number into criminal justice system, and probationary requirements are well adhered to by assailants. Thus, it appears that interventions oriented toward achieving legal accountability are an important and well understood goal.

Treatment for assailants and potential assailants was linked with two important and consensual outcomes--using constructive alternative strategies to cope with aggressive and sexual feelings and relating to women as human beings rather than objects.

The emphasis on assailants' behavior change points to the need to develop behavioral strategies aimed at the specific outcomes given priority. Treatment strategies need to focus on attitudes toward women and on alternative skills training. There is need for further research and demonstration projects concerning these treatment strategies for assailants and alternative strategies for potential assailants. In addition, training programs for practitioners need to address these issues.

With regard to the most frequently checked methods for achieving the aims under the assailant intervention section, respondents endorsed the following techniques (see Appendix B): (1) To treat and rehabilitate assailants, self help groups, social skill training, individual therapy and sex-role resocialization training were most frequently checked; (2) To hold assailants legally accountable, specialized sexual assault prosecution units and community based law enforcement auxillary programs were most frequent; (3) To treat potential assailants, individual therapy and sex role resocialization programs were most frequent. These methods give direction for further research.

The special considerations for assailants fell into three major categories: (1) causes and motivations of sexual assault; (2) interventions--treatability and obstacles; (3) enforcement of laws.

Sexual assault was viewed by 65% of the respondents as primarily violent. Two highly consensual and important motivations were the need to assert dominance and the need to express anger. Thus, respondents supported power and anger, rather than sexual motivations. With regard to causes, the most important were socialization to male role, institutionalized sexism and normal male sexuality.

These findings have direct implications for planning treatment approaches as discussed above. Intervention strategies need to focus upon helping assailants deal with their anger and need to assert dominance. Assertiveness training and sex role resocialization training may be useful approaches, particularly if focused upon behavioral and attitudinal change.

Respondents rated three criteria for treatability as important and highly consensual--the number of assaults, amount of violence, and assailant motivation. Thus, treatability is assessed primarily in terms of repetition and severity of assault as well as the purpose it serves. This would appear to imply that the most treatable assailant would be a first-time offender who did not exhibit severely violent behavior and may be motivated by a need to assert dominance. Similar to the victim section, these factors could be used as part of an initial assessment interview.

With regard to obstacles to treatment, highly consensual and highly important obstacles were inadequate treatment methods, social supports for coercive sexuality and low motivation to change. It would appear that there is need for further research and demonstration projects concerning treatment approaches and prevention strategies for addressing systems supportive of coercive sexuality. It is probable that societal tolerance of coercive sexuality must be changed as a prerequisite for long-range effectiveness of assailant interventions. In addition, training programs for practitioners need to address these issues.

With regard to enforcement of laws, 92% of the respondents indicated that all assailants were not equally likely to be apprehended and convicted. This finding is interesting in light of the earlier rating regarding outcomes for holding assailants legally accountable. Respondents rated as one of the lower items, with low consensus-- the assailants are representative of the larger group of those who are actually committing the crime. Thus, respondents believe that the assailants apprehended and convicted are not representative of the assailant groups, but do not see this as an important outcome of holding assailants accountable. This represents an important contradiction for the criminal justice field and warrants further study. The criminal justice system needs to develop strategies to make the group more representative; the strategies discussed below give some direction for exploration.

Respondents endorsed four strategies for alleviating this enforcement problem--court monitoring, research study of the relationship between rate of apprehension/conviction and population makeup of the community, community review boards, and legal reform concerning the definition of sexual assault. These strategies all involve the gathering of additional information so that more effective methods of accountability can be devised.

Primary Prevention

The three goals for primary prevention all received high importance and high consensus. Thus, there appear to be three interdependent high priority aims for prevention of sexual assault:

--to change structural features of social institutions
--to change people's attitudes/beliefs
--to change people's behavior

With regard to specific outcomes for changing structural features of social institutions, the most valued outcomes focus on changes in the areas of family, education, and advertising/media. There is less valued focus on modification of work places (except for item-- all workplaces ensure that women are not exploited or oppressed"--which received high importance) and religious institutions. It appears that schools and families are seen as having the most influence on human development, a finding which is not surprising. However, it is suggested by the authors that these institutions can be viewed simultaneously as part of the problem and part of the solution. With the media, it appears that respondents view this system as capable of spreading a wide net to raise public awareness. This system may also be seen as part problem and part solution. Thus, it would appear that if structural changes within these systems are desired, the first step for implementation is to increase awareness of the relationships between family environment and formal educational environment to the sex-role socialization of children in the culture at large. Then, there is a need to increase awareness of how policies and practices in each system support coercive sexuality.

Outcomes for changing people's attitudes and beliefs are uniformly rated as very important with high levels of consensus. The one item receiving 100% consensus (rating of 5.0) was people have intolerance for any victimization of others. The authors think it is important to note that sexual assault does not occur in isolation and that rape prevention programs involve many of the same elements required to prevent other kinds of destructive behaviors. Thus, it would seem desirable to integrate rape prevention efforts with all other prevention programs.

Agreement about most of the outcomes for changing behaviors is also strong. Two of the male-oriented outcomes reeched 100% consensus (5.0 rating)--not engaging in any coercive sexual behavior and dealing with anger toward others constructively. These desired outcomes for men in general are the same as the outcomes for assailants; these results appear consistent with the view that sexual assault is an extension of normal male socialization patterns. The highest woman-oriented outcome is that females exhibit confidence in their own skills and abilities. One of the issues that needs to be explored for women is what are the most effective strategies for learning to be self-confident, self-reliant and assertive.

While the goals and outcomes for prevention appear to be clear, there is uncertainty about the effectiveness of prevention strategies. (It should be noted that ratings for prevention strategies are of effectiveness, not importance.) Thus, respondents appear to see primary prevention efforts as desirable, but are uncertain about what can be done. This may reflect confusion, lack of adequate information, and/or value conflicts. There appears to be a need to generate and test out alternative prevention strategies and to determine the sources of the obstacles to social change.

The following chart represents the strategies rated by respondents as the most effective for each of the goals.

	Prevention Strategies	
to change structual features	to change attitudes and beliefs	to change behavior
non-sexist educational efforts (high consensus)	parent education training	non-sexist curriculum development in schools
legislative lobbying approaches	non-sexist curriculum development in schools	sex role education training for teachers
consultation for curriculum development in schools	sex role education training for teachers	parent education training
	(all high consensus)	(all high consensus)

Similar to the desired outcomes which focused on changes in family and school systems, the most effective strategies again focused on educational and training activities directed at family and school. Only one effective strategy--legislative lobbying approaches--had broader implication. Factor analysis of all the prevention strategies resulted in five factors: Generic Sex Role Change; Structural/Political Change; Behavior Change; Attitudinal Change; Public Opinion Change. These factors may be helpful in developing further research studies on prevention strategies.

At the present time, it appears that knowledgeable workers in the field are not certain about where they have the most clout; i.e., in what arenas and using which strategies do mental health, health, criminal justice, etc. workers have the most effective impact. This is probably true of all primary prevention efforts at this time. Broad scale social change is not easy to accomplish.

The authors would suggest that there are two sides of the question--on the target side, what is effective; on the initiation side, who is the most effective agent. Further research and demonstration projects are needed to address both sides. In addition, the development of more refined evaluation methods is needed in order to measure the effectiveness of prevention strategies.

With regard to special considerations for primary prevention, three broad concerns were addressed: (1) fundamental causes of sexual assault; (2) decisions about targeting prevention efforts; (3) community education strategies.

The top three causes (high importance, high consensus) involved social structural explanations--high prevalence of violence in society, social conventions perpetuating sexism, social structures which promote power discrepancies between males and females. The causes rated the lowest (with high consensus) were concerned with sexual instincts/behaviors--natural sexual instincts, female style as enticing, and blurring of roles between men and women.

Again, it appears clear that primary prevention efforts need to address these societal level issues. However, further research is needed regarding the factors perpetuating violence, sexism, and oppression, as well as research exploring the most effective strategies to address these factors. It appears that prevention efforts directed toward reducing or eliminating sexual assault need to be implemented within a theoretical framework that encompasses violence in general.

With regard to prevention efforts, the institutions cited as main targets were education, family, and advertising/media. These are the same institutions rated by participants as highly important foci in affecting structural changes to prevent sexual assault.

The individuals/groups regarded as major targets (to start with "first") were early adolescents (37%), general public (31%), elementary school children (18%) and adolescents (7%). However, when asked to judge which segments of the population are at highest risk, 100% of the respondents designated both early adolescents and adolescents as particularly vulnerable. The next groups desigated as high risk were adult women (96%), elementary age children (90%), lower socioeconomic groups (86%), young children (82%), disabled people (82%), non-Caucasian groups (80%), elderly people (74%). Thus, it would appear that the first priority effort for primary prevention would be an educational program directed at adolescents and early adolescents offered within the school structure.

The curriculum for such a program could focus on skill training; adolescent females could learn skills in acting assertively and feeling confident in their abilities, while adolescent males could learn skills in dealing with their anger constructively. In addition, other prevention efforts could be designed to focus on the high risk groups in priority order.

With regard to a model of community education, 90% of the participants felt that individuals and/or institutional systems could be motivated to change even if they are not reacting to a stressful situation. This finding does appear to support the feasibility of widespread prevention efforts.

In community education efforts, 88% supported the strategy of raising audience anxiety to present issue of susceptibility by indicating that rape can and does happen to anyone, anytime, anywhere. With regard to presenting the issue of severity, 100% supported emphasizing that it is an emotionally traumatic experience which can have serious consequences but from which victims do recover and may even be emotionally stronger. These findings appear to define a community education model in which the issues of susceptibility and severity are addressed by raising audience anxiety and emphasizing both positive and negative consequences of the emotional impact.

Training

The victim intervention, assailant intervention and primary prevention sections each contained a set of items dealing with knowledge, sensitivity and skills needed by practitioners in each of those areas. These have implications for needed outcomes for practitioner training.

With regard to victim intervention, participants rated most of the 22 items as important. The top four priority abilities were accorded the highest importance score (5.0) with 100% agreement among respondents--ability to conduct interviews nonjudgmentally, to communicate respect and concern, to conduct interviews in an ethical and responsible manner, and to provide sensitive and effective intervention which minimizes the chance for any further emotional stress. Factor analysis of the items yielded four factors: (I) Generic Interview Skills, (II) Intervention Procedures, (III) Effective Knowledge Base, (IV) Identification of Intervention Targets.

About half of the 15 items for providers in relation to assailant intervention were seen as very important with high consensus. These included a range of generic interview skills similar to those rated important under the victim section. In addition, items rated important included treatment specific skills and effective use of legal and community resource information. Factor analysis yielded three factors, similar to those obtained for victim intervention: (I) Intervention Procedures, (II) Generic Interview Skills, (III) General Accountability.

With regard to training implications, it appears that for practitioners/ providers for both victim and assailant interventions training programs could be designed involving, first of all, generic interview skills. This component of training would address increasing abilities having to do with ethical and sensitive provider behavior. A second component of training could address specific intervention procedures with either victim or assailant, and would include ability to apply knowledge of psychological and sociological dynamics, to identify coping with specific emotional reactions, to apply knowledge of cultural background. A third component of training could address specific knowledge necessary in the interventions, including medical and legal procedures and use of community resources.

For primary prevention providers, 10 items were rated by respondents. Most of the abilities were rated as important, while half reached a high level of consensus. The first two abilities--to communicate ideas clearly and persuasively, and to use community resources effectively--elicited 100% consensus (5.0 rating). Mastery of group process skills, however, received the lowest importance rating and moderate consensus.

Factor analysis did not yield separate domains for these skills. It appears that the skill domains could not be conceptualized distinctly. The chief means for focusing the resources that are potentially available for primary prevention may be through the facilitating, brokering, and modeling efforts of practitioners in the prevention field. These operating roles and tasks may require knowledge and skills that are new, including institutional change strategies, information linkage, power brokering. Further research to develop a body of knowledge, including long-term prevention strategies and the skills necessary to implement them, needs to be undertaken to guide training efforts in primary prevention.

With regard to methods for acquiring the skills defined under victim, assailant, and prevention sections, respondents endorsed three major techniques (see Appendix B): (1) In service education/training; (2) formal education or professional school; (3) work experience. Effectiveness of these techniques should be studied further.

RESEARCH IMPLICATIONS

Four broad kinds of research implications can be drawn from the procedures employed in this study and the results they have generated. (1) Methodological implications include recommendations for future sorts of research procedures applicable across a range of substantive concerns. (2) Implications for implementation are based on results in question areas where sufficient expert consensus exists to recommend development of model programs or evaluation research. (3) Value conflict resolution research can be guided by data analyses that yielded disagreements between groups of participants. Such results form the basis for recommendations about research related to clarification and resolution of important differences in judgment. (4) Finally, the Delphi Study suggests issues for knowledge gathering research. Even after three rounds of questioning and feedback, there remained areas of uncertainty among experts in the field of sexual assault. Such areas generate implications for projects designed to increase knowledge.

In what follows, we do not attempt to review specific results in detail or to develop all potentially useful research implications. Rather, we provide guides, suggestions and examples so that interested practitioners and researchers can use this monograph as a resource for designing future investigative efforts. As we have noted, questionnaire results strongly support the thesis that there is a great deal of agreement about the meaning of central terms and the structure of basic concepts in the sexual assault field. Consequently we assume that major results from this study can be helpful to investigators with differing value orientations in the development of myriad types of research projects

Methodological implications. Two methodological features of this study are expected to prove valuable in future research in a number of topic areas. The Delphi questioning technique seems to us a viable approach to be used for investigating consensual standards in any area where expert knowledge forms an important part of the foundation. Such an approach, then, may be useful in any emerging field where standards of practice are needed, where guidelines for intervention rather than "facts" are sought, where value conflicts need to be clarified, and where it is desirable to identify areas of existing uncertainty. For example, family violence and child custody arrangements constitute two areas for which research relying on Delphi techniques would be appropriate.

The second methodological feature to which we wish to draw attention is the discourse analytic approach to review of relevant literature. While discourse analysis is not itself a new procedure, its use for conducting a literature review in support of a research effort is innovative. Most research proposals begin with a state-of-the-art literature review, and subsequent research activity typically attempts to build systematically on published resources. The discourse analytic approach serves to organize background materials; to reduce bias in review of relevant text; and to make explicit the major assumptions, values and belief systems in a body of information. In the end, it can provide a mechanism by which project staff can critically review its own reports.

Implementation research. Any questionnaire result sections that manifested high levels of consensus and priority in our view legitimately serve as the basis for future implementation research. By "implementation" research we mean any systematic efforts to install and judge the effectiveness of sexual assault intervention or prevention activities guided by the results reported here. Such efforts may take the form of a model project or projects designed to reach a set of high priority goals. Or they may take the form of evaluation research focussed at determining the extent to which existing programs or services are meeting valued objectives.

Concerning victim intervention, analyses highlighted four top priority goals that such programs should address; in addition, they identified many consensually valued outcomes associated with them. For instance, developing detection and referral skills among staff of educational and other community agencies was seen as a valued outcome and is well suited to demonstration or evaluation research. Such a project might provide training programs to the personnel in an identified set of schools and other organizations aimed at detection and referral procedures; after completing the programs, the project would determine whether accurate identification and referral of sexual assault victims had increased in the targeted agencies, especially in comparison with organizations that had not received the programs. Other examples of outcomes appropriate for demonstration evaluation research include reducing the incidence of sexual assault through environmental and safety factors, or reducing repeat incidence among victims. In addition, the four-fold breakdown of provider skills described in the victim intervention section of the Results chapter could help supply the basis for research that designs and evaluates the effectiveness of practitioner training courses.

With respect to assailant intervention, program demonstration or evaluation should be directed toward the three goals widely acknowledged to be important across participant groups. In view of the unequivocal emphasis given to outcomes involving assailants' behavior change, research is primarily recommended to determine the most effective strategies for inducing such efforts. For example, rehabilitation research projects showing effective ways of teaching the constructive expression of anger to assailants would be highly desirable. And, as we noted in relation to victim intervention, the categorization of provider skills required for effective assailant intervention should provide a foundation for demonstration and/or evaluation of practitioner training projects.

Finally, the three interdependent and high-priority goals for primary prevention along with their associated outcomes can become an important focus for research. Specifically recommended are demonstration and evaluation research projects aimed at producing changed sex role structures, behaviors, and attitudes in families, educational institutions, and advertising media. Concurrently, efforts to implement and assess the effectiveness of different educational and training strategies to produce such changes are needed.

Value conflict resolution research. In addition to the sorts of research directions described above, investigative efforts may focus on clarifying value conflicts and resolving areas of disagreement in the sexual assault field. Each of the results sections in the preceding chapter identifies issues with respect to which such research may be fruitfully undertaken. For these purposes, it might be helpful to survey in further detail the evaluative judgments of different groups of individuals (e.g., providers, consumers) or to hold conferences that provide a forum for interactive exploration of differing perspectives.

For example, the issue of roles for educators in detecting high-risk families is a controversial one that could be explored by more detailed surveys or interactive conferencing. Disagreements about the value of attempts to involve educators in detection of incest families probably turn on a number of related points:

--Do we have clear-cut and reliable criteria for detection?
--If so, can education personnel (who lack mental health training or work experience) be taught to employ them well by means of short courses or workshops?
--Is it legitimate to request educational institutions to become involved in intrafamilial matters of this sort?
--If so, would individual educators feel comfortable in this role?

Each of these points warrants inquiry for the purpose of understanding conflicts about educators' roles in relation to incest families and possible approaches to resolving them. Other issues that lend themselves well to this type of research in the area of victim intervention include, for example, how best to minimize risks to potential victims, how and whether to restore victims' or incest families' sense of trust, and enforcement of reporting laws. In addition, the value of specific treatment guidelines elicited participant disagreement (for instance, whether adult victims necessarily need counseling, whether male providers should be used in intervention programs, whether self-defense skills are useful secondary prevention techniques); these provide very precise foci for future research directed toward resolution of disagreement among knowledgeable practitioners in the sexual assault field.

Even greater respondent disagreement emerged in relation to questions about assailant intervention. Here clarification of the importance of legal accountability and the value of treating potential assailants is warranted; these are major intervention goals whose status differs among expert participants. It would be well also to undertake values clarification research aimed at illuminating the interpretation of assailant motivations and the differential importance placed on outcomes involving behavioral change as opposed to intrapsychic growth. Finally, research is recommended to address differential assessment of the obstacles to effective assailant treatment.

In primary prevention, value conflicts centered on the relative importance of changing institutional structures and changing people's behavior as goals. In this area, too, conflict resolution research is warranted. In addition, differing judgments about fundamental causes of sexual assault deserve exploration in this manner.

Knowledge gathering research. Research implications included under this heading are most broad and vague. Every section of the Result chapter specified questions where uncertainty prevailed even among responses from the most knowledgeable individuals in the sexual assault field. Clearly all such questions form potential topics for research aimed at acquiring knowledge. While specific research approaches cannot be recommended for these topics, the data suggest general directions for future pursuit.

While the topic of victim intervention produced the most well-defined results, areas of uncertainty nonetheless emerged. For example, participants were uncertain whether children's fears of treatment systems constitute an obstacle to juvenile intervention. To shed light on this question, it would be desirable to interview children--both pretreatment clients and nonclients--in order to tap beliefs, feelings, and attitudes related to mental health settings. Juvenile clients ought to be assessed during and after treatment as well, to see whether initial fears (if any) are allayed by the treatment process and do or do not constitute continuing obstacles to intervention. Difficulty in communicating about sexuality with child victims is another hypothesized obstacle to treatment of juveniles that deserves similar research. The usefulness of several specific intervention guides (e.g., generic features of trauma reaction) was an open question also susceptible to knowledge gathering research. Finally, certain of the proposed provider skills (e.g., ability to collect evidence in accord with legal requirements) were of uncertain value and merit data acquisition.

With respect to assailant intervention, a great deal of knowledge gathering is needed. In general, this area suffers a lack of common understanding about treatability per se, about obstacles to treatment, and best treatment strategies to follow. Each of these could stand as a major research study question; resulting knowledge would contribute foundation-level understanding for policy and practice in assailant intervention. Similarly, the prevention area elicits a great deal of general uncertainty about the value and efficacy of strategies for achieving primary change, i.e., change aimed at alleviating the conditions that support or tolerate sexual assault. In view of the social importance of this issue area, we recommend the initiation of major knowledge gathering research efforts directed at how to alter social and institutional structures that permit violent or aggressive interpersonal behavior.

Policy Implications

Social and legal policy has implicitly dichotomized rape as either a "criminal" or "social" problem. In the authors' view it is both at once. Activities aimed at reducing violent crime (including law enforcement) and those aimed at improving conditions (prevention and treatment) are complementary. They can become more mutually supportive, we believe, if their interrelationship is explicitly included in policy statements. Policy implications must address first the definition of rape and sex-related offenses.

Definitions. Each state has its own definition of rape within its criminal statutes. The FBI defines forcible rape as "criminal knowledge of a female through the use of force or threat of force" (U.S. Department of Justice, FBI, 1975). In the Delphi Study participants were asked to rate a number of definitions with respect to both quality and desirability and with respect to practicality as an operating definition. Of the five definitions provided for sexual assault, the simple definition "forced sexual activity" was regarded by 80% of respondents as the best in terms of both quality and practicality. None of the others, including the legal definition, were regarded as qualitatively desirable or very practical. In fact, the legal definition was consensually agreed upon (85%) not to be practical. These findings are consistent with the earlier high rating of "legal reform concerning the definition of sexual assault" as a desirable strategy under the assailant section. It appears clear that knowledgeable workers see the need for changes in definition.

Respondents were also asked to consider a list of possible labels for designating major sexual assault concepts. For labeling the concept of an act in which someone has been forced to engage in some kind of sexual activity, the term "sexual assault" was clearly preferred (98%). The label "rape" received a highly mixed response (45% yes; 55% no). These data suggest that participants prefer a label that connotes a broader interpretation, rather than a more narrow but more common one.

Respondents were also asked to arrive at consensus about how best to build an explanatory structure for sexual assault, or to determine where to bound the interpretation of the concepts involved. Three dimensions were taken into account: the relationship between assailant and victim, the range of sexual activity involved, and the degree of coercion. Ninety-eight percent of the respondents chose the broadest boundary level for the dimension of relationship to victim; for the dimension of range of sexual activity, 69% of the respondents chose to bound the concept with display of genitals in a sexual context, without physical contact; with respect to degree of coercion, 55% included implied threat (non-verbalized, but perceived).

Thus, it appears that knowledgeable workers in the field support a broadening of the emphasis to any forced sexual activity, with less emphasis on a specific sexual act or identity of participants. Further efforts should be designed to address these issues immediately and to help shape future legislative documents. This explanatory framework can also be used as the basis of curriculum development for primary prevention efforts.

Before leaving the discussion of sexual assault terminology, one other label warrants attention. High consensus was also attained for terms designating a person who has been forced to engage in some kind of sexual activity. Ninety-four percent of participants endorsed the label "victim"; in contrast, 79% indicated that the term "survivor" should not be used. At the present time, in all the areas of study of victimology, there appears to be controversy regarding the use of "victim" vs. "survivor." Our data reflects consensus in the use of the term "victim" in the sexual assault prevention and treatment fields.

Treatment. With regard to policy concerning treatment, it appears that the federal and state governments can play an important role in maintaining a widespread treatment capacity and in providing technical assistance, research, demonstration and evaluation in the area of treatment/intervention. Treatment issues to be addressed include treatment priorities, treatment types, and quality of care. With regard to treatment priorities, the questions of which victims should be given priority need to be addressed. For treatment types, we need to address the issue of the most cost-effective type of treatment/interventions. It is recommended by the authors that the intervention strategies which have not gone through the same validity process in our study now be examined, fleshed out and turned into practical actions. Studies such as the Delphi Study and regional and national conferences should be implemented to ask "what is being done," "what can be done" and "what should be done."

With regard to quality of care, it is recommended that there be accelerating skill training for workers in the field through in-service training programs and that sexual assault treatment be incorporated into required curricula of all professional schools. In addition, the relationship between treatment and criminal justice agencies has often been impeded by procedural obstacles, mutually shared suspicions and differing belief systems and inadequate cooperation. These areas should be addressed to an even greater extent now, and collaborative interventions be supported by means of policy.

Prevention. The lack of a sophisticated technology for primary prevention, at the present time, needs to be addressed. Given the connection between criminal and social aspects of sexual assault, this lack is a serious one. At the policy level there needs to be a commitment to provide support and resources and a clear sanction and mandate for primary prevention activities. As with treatment policy, it appears that the federal and state governments can play an important role in developing a widespread prevention effort. With regard to allocation of resources, participants endorsed the following breakdown: 40% of effort for victim intervention, both adult and child; 31% of effort for primary prevention; 28% for intervention with assailants, divided equally between treatment and legal accountability.

Action research; policy development toward social change aimed at the reduction of non-constructive expression of anger and feelings of powerlessness; establishment of a climate where coercion/oppression is not tolerated; and planned change in social perceptions and behaviors across sex roles so that men and women construe themselves as peers in all interpersonal transactions, are all important areas for mental health professionals and community agency personnel. These areas can be used to define a national prevention effort.

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APPENDIX A: DELPHI QUESTIONNAIRE

DELPHI QUESTIONNAIRE

CARD 01

ID# ☐☐☐☐☐☐☐☐☐☐☐☐ 1-12/

Round 3 13/

The third round Questionnaire is identical in content and format to the second. That is, the first two sections of this Questionnaire broadly concern intervention with victims and with assailants. We are interested in exploring standards for service, including programs in mental health, medical, criminal justice, and social services.

We have provided you with lists of possible responses under each heading as a basis for your answers. In addition, we have provided a summary of responses from the second round. This information, printed below or beside the space for current responses, is typically presented as percentages of responses that were given for each alternative listed. Please consider these data in responding to Questionnaire items.

REMINDER: THIS QUESTIONNAIRE MUST BE MAILED BY:

INTERVENTION WITH VICTIMS SECTION

INTERVENTION GOALS FOR VICTIMS

Instructions

Below is a list of generic intervention goals for victims. For each goal listed, rate how important it is to intervention with victims, using the 5-point scale shown below. Importance refers to the degree of priority you would give to this goal. The higher the number, the higher your estimate of the goal's importance. The lower the number, the less important the goal. If you believe an item listed is not in fact a goal, please also rate it as "1."

1	2	3	4	5
Not Important or Not a Goal		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Goals		Importance					
To minimize the risk to potential victims of being sexually assaulted/abused		1	2	3	4	5	14/
	*	0%	0%	2%	8%	90%	
To identify sexually assaulted/abused individuals		1	2	3	4	5	15/
	*	2%	0%	8%	49%	41%	
To assist victims in coping with the emotional impact of the sexual assault/abuse and to prevent further emotional distress		1	2	3	4	5	16/
	*	0%	2%	0%	2%	96%	
To assist victims in coping with the physical trauma associated with the sexual assault/abuse		1	2	3	4	5	17/
	*	0%	2%	0%	14%	84%	
To assist victims in coping with the criminal justice system procedures		1	2	3	4	5	18/
	*	0%	0%	4%	65%	31%	
To assist the families and friends of victims in coping with the emotional stress associated with the sexual assault/abuse		1	2	3	4	5	19/
	*	0%	0%	4%	76%	20%	
To assist incest families in coping with the emotional stress associated with the sexual assault/abuse		1	2	3	4	5	20/
	*	0%	0%	0%	8%	92%	

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 1

To minimize the risk to potential victims of being sexually assaulted/abused

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 1, using the 5-point scale shown below. Importance refers to the degree of priority you would give to this outcome. The higher the number, the higher your estimate of the outcome's importance. The lower the number, the less important the outcome. If you believe an item listed is not in fact a desired outcome, please also rate it as "1."

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcome		Importance					
The incidence of sexual assault/abuse among high-risk individuals is reduced		1	2	3	4	5	27/
	*	0%	0%	0%	6%	94%	
High-risk individuals and vulnerable segments of the population are identified		1	2	3	4	5	28/
	*	0%	2%	8%	72%	18%	
Service providers have skills in identification of high-risk individuals		1	2	3	4	5	29/
	*	0%	2%	10%	68%	20%	
Educators have information on how to detect high-risk children and families		1	2	3	4	5	30/
	*	0%	4%	6%	68%	22%	
Potential victims know self-defense and other protective skills		1	2	3	4	5	31/
	*	4%	2%	20%	50%	24%	
Potential victims are aware of the risks of their environment and actively plan to minimize them		1	2	3	4	5	32/
	*	0%	0%	0%	10%	90%	
Potential victims are aware of safety measures against sexual assault/abuse		1	2	3	4	5	33/
	*	0%	0%	2%	8%	90%	
Potential victims understand the nature, scope and severity of sexual assault/abuse		1	2	3	4	5	34/
	*	0%	2%	10%	58%	30%	
Potential victims have good support systems in their community		1	2	3	4	5	35/
	*	0%	0%	4%	8%	88%	
Community environments are structured to provide safety and protection of individual residents		1	2	3	4	5	36/
	*	0%	0%	0%	8%	92%	

79-80/01

*last round responses (percentages)

CARD 2-1/6

79-80/02

CARD 3 1-6

DESIRED OUTCOMES FOR GOAL 2

To identify sexually assaulted/abused individuals

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 2, using the 5-point scale as you did for goal 1.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance 1	2	3	4	5	
All sexually assaulted/abused individuals are identified	*	6%	4%	4%	45%	41%	19/
Repeated incidence of sexual assault/abuse is reduced among sexually assaulted/abused individuals	*	0%	0%	0%	4%	96%	20/
Service providers have skills in early detection of sexually abused/assaulted individuals	*	0%	0%	2%	10%	88%	21/
Sexually assaulted/abused individuals contact sexual assault services	*	2%	0%	8%	67%	23%	22/
Community members have information on how to detect and refer possible sexual assault/abuse situations	*	0%	0%	2%	27%	71%	23/
Laws regarding reporting of sexual assault/abuse incidents are enforced	*	4%	2%	8%	33%	53%	24/

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 3

To assist victims in coping with the emotional impact of the sexual assault/abuse

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 3, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

. Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes	Importance					
The victim understands that the responsibility for the assault/abuse lies with the assailant	1	2	3	4	5	67/
	* 2%	0%	0%	2%	96%	
The victim understands and anticipates her/his own emotional reactions to the assault/abuse	1	2	3	4	5	68/
	* 0%	0%	0%	2%	98%	
The victim expresses the range of different feelings she/he has experienced concerning the assault/abuse	1	2	3	4	5	69/
	* 0%	0%	6%	22%	72%	
The victim has a support system of family, friends and/or peers which assists her/him cope with the assault/abuse	1	2	3	4	5	70/
	* 0%	0%	0%	4%	96%	
The victim's emotional symptoms of distress have decreased	1	2	3	4	5	71/
	* 0%	0%	4%	12%	84%	
The victim is coping at her/his previous level of psychological functioning or higher	1	2	3	4	5	72/
	* 0%	0%	0%	12%	88%	
The victim has a restored sense of self-worth	1	2	3	4	5	73/
	* 0%	0%	0%	0%	100%	
The victim has a restored sense of trust in other people	1	2	3	4	5	74/
	* 2%	0%	12%	63%	23%	
The victim has the coping skills to reduce her/his vulnerability to repeated assaults/abuse	1	2	3	4	5	75/
	* 0%	0%	2%	2%	96%	
The victim's living situation provides a safe environment	1	2	3	4	5	76/
	* 0%	0%	0%	16%	84%	
The victim feels understood and believed by the service provider concerning her/his assault/abuse experience	1	2	3	4	5	77/
	* 0%	0%	0%	0%	100%	
The victim and her/his family and friends have the necessary information concerning reporting options	1	2	3	4	5	78/
	* 0%	0%	6%	16%	78%	79-80/03 CARD 4 1-6

- *last round responses (percentages)

79-80/04

CARD 5 1-6

79-80/05

DESIRED OUTCOMES FOR GOAL 4

To assist victims in coping with the physical trauma
associated with the sexual assault/abuse

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 4, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

CARD 6 1-6

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance					
The victim and her/his family and friends have the necessary information concerning how the medical procedures will be conducted		1	2	3	4	5	32/
	*	0%	0%	0%	2%	98%	
The victim's confidentiality is maintained		1	2	3	4	5	33/
	*	2%	0%	0%	6%	92%	
The victim receives medical treatment which meets the legal requirements for reporting and for evidence collection		1	2	3	4	5	34/
	*	0%	0%	6%	19%	75%	
The victim feels understood and believed by the medical service providers		1	2	3	4	5	35/
	*	0%	0%	2%	6%	92%	
The victim and her/his family and friends receive necessary emotional support services needed to deal with the physical trauma		1	2	3	4	5	36/
	*	0%	0%	2%	0%	98%	
The victim's physical condition is restored to her/his previous level of functioning		1	2	3	4	5	37/
	*	0%	0%	2%	6%	92%	
The victim and her/his family and friends understand the reporting options available		1	2	3	4	5	38/
	*	0%	0%	2%	29%	69%	

79-80/06

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 5

To assist victims in coping with the criminal justice procedures

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 5, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

CARD 7 1-6

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance					
The victim is interviewed a minimum of times		1	2	3	4	5	19/
	*	0%	0%	0%	29%	71%	
The victim feels understood and believed by criminal justice service providers		1	2	3	4	5	21/
	*	0%	0%	0%	6%	94%	
The victim has someone from within the criminal justice system who is negotiating for her/him		1	2	3	4	5	22/
	*	0%	2%	6%	18%	74%	
The victim's civil rights are protected		1	2	3	4	5	23/
	*	0%	0%	0%	0%	100%	
The victim and her/his family and friends have the necessary information concerning the legal procedures and the investigation		1	2	3	4	5	24/
	*	0%	0%	0%	4%	96%	
The victim is interviewed in her/his own language		1	2	3	4	5	25/
	*	0%	0%	0%	8%	92%	

DESIRED OUTCOMES FOR GOAL 6

79-80/07

To assist the families and friends of victims in coping with the emotional stress associated with the sexual assault/abuse

CARD 8 1-6

Desired Outcomes		Importance					
Victim's family and friends understand and can express their own set of emotional reactions to the assault/abuse		1	2	3	4	5	7/
	*	0%	0%	0%	31%	69%	
Victim's family and friends have a support system which assists in their coping with the impact of the sexual assault/abuse		1	2	3	4	5	8/
	*	0%	0%	2%	27%	71%	
Victim's family and friends have made effective use of available community resources		1	2	3	4	5	9/
	*	0%	2%	8%	61%	29%	
Victim's family and friends have understood and coped with the emotional impact of the sexual assault/abuse incident		1	2	3	4	5	10/
	*	0%	0%	0%	8%	92%	
Victim's family and friends take an active role in emotionally supporting the victim		1	2	3	4	5	11/
	*	0%	0%	2%	8%	90%	
Parents of child victims have the knowledge to assist in the child's sexual and social adjustment to the sexual assault/abuse		1	2	3	4	5	12/
	*	0%	0%	0%	0%	100%	

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 7

To assist incest families in coping with the emotional
stress associated with the sexual assault/abuse

Instructions

Below is a list of desired outcomes that might be included under intervention with victims. For each outcome, rate how important it is to meeting goal 7, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcome		Importance					
Communication among family members is improved		1	2	3	4	5	55/
	*	0%	2%	0%	12%	86%	
Family members are coping at their previous level of functioning or higher		1	2	3	4	5	56/
	*	2%	0%	2%	8%	88%	
All family members use new and/or improved ways to deal with conflicts and stress		1	2	3	4	5	57/
	*	4%	0%	2%	12%	82%	
All family members hold the sexual abuser accountable for his/her actions		1	2	3	4	5	58/
	*	0%	2%	2%	14%	82%	
Family members use appropriate community services to prevent further incidents		1	2	3	4	5	59/
	*	0%	0%	0%	12%	88%	
The family has an improved sense of trust among all its members		1	2	3	4	5	60/
	*	6%	2%	16%	60%	16%	
Family members have appropriate roles in the family system		1	2	3	4	5	61/
	*	8%	2%	4%	18%	68%	
Child victim's account of the sexual abuse is believed by all family members		1	2	3	4	5	62/
	*	0%	0%	4%	6%	90%	
The family has understood and coped with the emotional impact of the sexual assault/abuse		1	2	3	4	5	63/
	*	0%	0%	0%	4%	96%	79-80/08

*last round responses (percentages)

KNOWLEDGE/SKILLS/SENSITIVITIES NEEDED BY SERVICE PROVIDERS

FOR INTERVENTION WITH VICTIMS

CARD 9 1-6

Instructions

79-80/09

Below is a list of knowledge, skills, and sensitivities that a service provider may need to function adequately in intervention with victims. For each provider qualification listed, rate how important it is to intervention with victims, using the 5-point scale shown below. Importance refers to the degree of priority you would give to this qualification. The higher the number, the higher your estimate of the provider qualification's importance. The lower the number, the less important the qualification.

1	2	3	4	5
Not Important		Somewhat Important		Very Important

CARD 10 1-6

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Knowledge, Skills, Sensitivities	Importance					
	1	2	3	4	5	
Ability to adjust intervention choice and approach according to the developmental stage of the victim	* 0%	0%	0%	8%	92%	43/
Ability to apply knowledge of the psychological and social dynamics of sexual assault to intervention with individual victims	* 0%	0%	2%	4%	94%	48/
Ability to adjust intervention choice and approach according to the type of sexual assault/abuse	* 0%	0%	2%	35%	63%	53/
Ability to provide intervention which takes into account the cultural background of the victim's family	* 0%	0%	2%	4%	94%	58/
Ability to conduct interviews in a nonjudgmental manner	* 0%	0%	0%	0%	100%	63/
Ability to obtain needed information from the victim and her/his family and friends in a nonintrusive manner	* 0%	0%	4%	18%	78%	68/
Ability to communicate respect and concern for the victim and her/his feelings during interviews	* 0%	0%	0%	0%	100%	73/ 79-80/10 CARD 11 1-6
Ability to conduct interviews in an ethical and responsible manner	* 0%	0%	0%	0%	100%	7/

*last round responses (percentages)

Knowledge, Skills, Sensitivities	Importance					
	1	2	3	4	5	
Mastery of crisis intervention techniques	* 0%	0%	2%	8%	90%	12/
Ability to identify specific emotional reactions the victim may be experiencing	* 0%	0%	0%	31%	69%	17/
Ability to identify specific emotional reactions the victim's family and friends may be experiencing	* 0%	0%	2%	67%	31%	22/
Ability to use community resources effectively	* 0%	0%	2%	16%	82%	27/
Ability to communicate knowledge regarding physiological and interpersonal aspects of human sexuality to victims	* 0%	0%	31%	49%	20%	32/
Ability to cope with one's own job-related stress and to find effective means of stress reduction	* 0%	0%	4%	25%	71%	37/
Ability to explain criminal justice system procedures	* 0%	0%	6%	41%	53%	42/
Ability to explain medical procedures	* 0%	0%	6%	39%	55%	47/
Ability to collect evidence in accordance with regional/state legal requirements	* 6%	0%	22%	47%	25%	52/
Ability to provide sensitive and effective intervention which minimizes the chance for any further emotional stress	* 0%	0%	0%	0%	100%	57/
Ability to assist family and friends of victim in using and coping with their own emotional reaction to the sexual assault/abuse	* 0%	0%	0%	27%	73%	62/
Personal insight of own reactions/attitudes towards sexual assault	* 0%	0%	6%	16%	78%	67/
Ability to accurately identify sexually abused/assaulted individuals on the basis of clinical information	* 2%	2%	8%	43%	45%	72/ 79-80/11 CARD 12 1-
Ability to identify high-risk individuals	* 2%	0%	8%	72%	18%	7/

*last round responses (percentages)

SPECIAL CONSIDERATIONS: VICTIMS

In the next section, we are interested in examining in greater detail special intervention issues involved in work with victims. These issues highlight value differences in the field of sexual assault/abuse. So, while we expect a great variety in responses, we are very interested in the range and the extent of consensus in expert opinion.

Specifically, we are asking you about criteria you think should be employed to assess the effectiveness of intervention with victims, special intervention considerations which you think should be taken into account in work with victims, and what guiding principles service providers ought to be following in work with victims. For each question, please examine the list of possible choices we have supplied as a basis for your responses.

1. Which of the following factors should be considered to guide effective treatment of victims (juvenile or adult)? Use the following 5-point scale to show the relative importance of these factors. Indicate your response by circling the appropriate number. Please consider responses from the previous round in making your decision.

1	2	3	4	5
Not Important		Somewhat Important		Very Important

		Importance					
		1	2	3	4	5	
Phases of victim's reactions	*	0%	0%	10%	76%	14%	26/
Developmental life stage of victim	*	0%	0%	8%	12%	80%	27/
Victim's responses to assault	*	0%	0%	0%	6%	94%	28/
Generic features of trauma reactions	*	4%	0%	8%	78%	10%	29/
Individual aspects of trauma associated with sexual assault	*	0%	0%	2%	14%	84%	30/
Conscious processes of victim	*	2%	0%	2%	12%	84%	31/
Unconscious processes of victim	*	8%	4%	53%	29%	6%	32/
Duration of assaultive relationship	*	2%	0%	10%	27%	61%	33/
Relationship of victim to assailant	*	0%	0%	2%	16%	82%	34/
Victim's ability to adapt to stress	*	0%	0%	2%	8%	90%	35/
Victim's family's ability to adapt to stress	*	0%	4%	0%	74%	22%	36/
Victim's cultural background	*	0%	2%	8%	57%	33%	37/

*last round responses (percentages)

2. Do victims need to receive counseling in order to recover from the trauma of sexual assault/abuse? Indicate your response by circling Yes or No, after considering previous round responses.

	Yes$_1$	No$_2$	
Juvenile victims	Yes$_1$	No$_2$	44/
	*79%	21%	
Adult victims	Yes$_1$	No$_2$	45/
	*52%	48%	

3. What are the major obstacles in treatment of juvenile victims? Use the following 5-point scale to indicate the importance of each obstacle. Indicate your response by circling the appropriate number, after considering previous round responses.

1	2	3	4	5
Not an Important Obstacle		Somewhat Important Obstacle		Very Important Obstacle

	Importance					
Lack of knowledge concerning child development	1	2	3	4	5	46/
	*6%	6%	59%	17%	12%	
Lack of knowledge concerning child sexual abuse treatment	1	2	3	4	5	47/
	*0%	4%	0%	12%	84%	
Child's fear of treatment systems	1	2	3	4	5	48/
	*2%	18%	45%	31%	4%	
General vulnerability/powerlessness of children in the adult world	1	2	3	4	5	49/
	*0%	4%	6%	12%	78%	
Socialization process which makes children, especially females, vulnerable to victimization	1	2	3	4	5	50/
	*2%	4%	6%	6%	82%	
Interviewer's anger toward assailant	1	2	3	4	5	51/
	*8%	17%	63%	6%	6%	
Difficulty in communicating with a child about sexuality	1	2	3	4	5	52/
	*0%	10%	29%	47%	14%	
Limitations of available options for protecting an abused child	1	2	3	4	5	53/
	*0%	0%	4%	8%	88%	

*last round responses (percentages)

4. What criteria should a service provider use in deciding when to make a report (police or protective service) concerning child sexual assault/abuse? Use the following 5-point scale to show the relative importance of these criteria. Indicate your response by circling the appropriate number, after considering previous round responses.

1	2	3	4	5
Not an Important Criteria		Somewhat Important Criteria		Very Important Criteria

		Importance					
Legal requirements		1	2	3	4	5	60/
	*	2%	2%	10%	10%	76%	
Relationship of child to assailant		1	2	3	4	5	61/
	*	23%	2%	12%	16%	47%	
Age of the child		1	2	3	4	5	62/
	*	34%	2%	26%	12%	26%	
Social supports available to the child		1	2	3	4	5	63/
	*	10%	4%	8%	14%	64%	
Effect on treatment		1	2	3	4	5	65/
	*	23%	0%	12%	22%	43%	

5. Do you think service providers should take the gender of the child into consideration in work with child victims? Circle Yes or No, after considering previous round responses.

	Yes_1	No_2	72/
*	92%	8%	

*last round responses (percentages)

6. Are there any kinds of working relationships that should be set up between the mental health service provider and the criminal justice system? Use the following 5-point scale to show the importance of each relationship. Indicate your response by circling the appropriate number, after considering previous round responses.

1	2	3	4	5
Not an Important Relationship		Somewhat Important Relationship		Very Important Relationship

Working Relationships		Importance					
Criminal justice worker calls in mental health provider at first contact with child victims and their families		1	2	3	4	5	73/
	*	4%	0%	8%	8%	80%	
Mental health provides consultation to criminal justice system in dealing with victims and their families		1	2	3	4	5	74/
	*	0%	0%	4%	4%	92%	
Criminal justice system provides consultation to mental health system in dealing with victims and their families		1	2	3	4	5	75/
	*	0%	0%	10%	12%	78%	
Ongoing case conferences are set up between two systems		1	2	3	4	5	76/
	*	0%	2%	10%	20%	68%	
Collaborative research projects are undertaken		1	2	3	4	5	77/
	*	4%	4%	29%	20%	43%	
Collaborative training programs are conducted		1	2	3	4	5	78/
	*	2%	2%	0%	12%	84%	79-80/12 CARD 13 1-6/

7. Do you think male service providers should be used in these roles? Circle Yes or No, after considering last round responses.

Counseling of female victims		Yes_1	No_2	9/
	*	67%	33%	
Prevention programs for potential victims		Yes_1	No_2	10/
	*	86%	14%	

*last round responses (percentages)

8. Which of the following approaches would you emphasize in teaching individuals how to minimize the risk of being sexually assaulted/abused? Circle one number only indicating the approach you would stress. In answering, please consider last round responses.

Stress a strategy of avoidance, pointing out safety measures that can be taken to avoid dangerous situations 1 * 18%

11/

OR

Emphasize a strategy of assertiveness, pointing out behavioral and attitudinal techniques to avoid acting like a victim 2 * 82%

9. Below is a set of counseling situations that might present conflicts or dilemmas for service providers. For each situation, select the choice that represents the focus that you would recommend using first, i.e. the treatment direction on which you would place priority. Circle the number next to your choice, after considering last round responses.

a. Mary, 16, was raped by a 25 year old man who offered her a ride when she was hitchhiking. She tells the counselor that she hitchhikes occasionally. Now she wonders if there is something self-destructive about her behavior. In helping Mary deal with her feelings, where would you recommend focusing the treatment first?

Reassure Mary that she is not self-destructive and not responsible for the rape 1 * 41%

12/

OR

Explore various decision-points in her assault experience to determine whether or not she has made self-destructive choices 2 * 59%

b. Suzanne, 13, has been sexually abused by her father since she was 9 years old. Her family is now seeing a counselor. Suzanne is feeling intense anger with both of her parents. In helping Suzanne to deal with her anger, where would you recommend focusing the treatment first?

Acknowledge the powerlessness of Suzanne's situation, including how impossible it is to adequately express her anger towards her parents 1 * 6%

13/

OR

Encourage Suzanne to express her anger towards her family during a counseling session 2 * 94%

c. Lucy, 40, mother of two toddlers, was assaulted in a parking lot. The assailant forced her to have oral sex as well as intercourse. During a counseling session, Lucy indicated that she feels dirty, can hardly eat and cannot think of ever having sex again. In helping Lucy deal with her feelings, where would you recommend focusing the treatment first?

Point out that rape is primarily violent, not sexual, and that her "feeling dirty" probably stems from the degrading nature of the assault 1 * 86%

14/

OR

Explore her experience with and feelings about her sexuality in order to discuss with her the impact of the sexual aspects of the assault 2 * 14%

*last round responses (percentages)

d. Eleven year old Stanley confides in the counselor that his father has been molesting him for several years. (This has not come up previously.) He says that he has told his mother about it twice, but she has not believed him, saying "What are you trying to do, son, break up this family?" Stanley begs the counselor to tell no one. The counselor explains that he must report any such abuse. Stanley then denies that the abuse really took place, saying that he made it up today because he was angry with his father. What would you recommend the counselor do next?

Proceed with the report 1 * 86% 84%

OR 15/

Reassure Stanley that no one will find out, and not make any report at this time 2 * 14%

e. In the situation described above with Stanley, if through family counseling it became clear that incest was taking place, how would you recommend the counselor deal with the living arrangement?

Arrange for the father to leave the household as soon as possible 1 * 78%

OR

Arrange for Stanley to live elsewhere 2 * 6% 16/

OR

Not change the living arrangements 3 * 16%

f. Maria's family recently emigrated to the United States from a South American village. Maria is betrothed, and she will be married in six months. She is brought to the emergency room by an acquaintance after having been sexually assaulted at knifepoint. If you were the emergency room social worker, what would you do first?

Continue to discuss Maria's situation with her 1 * 76%

OR 17/

Find another counselor from the same cultural background to help Maria 2 * 24%

g. Maria wants no one in her family to find out about the assault because she fears the marriage will be cancelled. What would you recommend the counselor do next?

Support her coping with anticipated family problems by not telling them at this time 1 * 90%

18/

OR

Support her coping with anticipated family problems by encouraging her to discuss her situation with her family 2 * 10%

*last round responses (percentages)

h. Maria became very upset when the emergency room social worker suggested that she come in the next day for counseling. Her family would be horrified if she discussed her "private problems" with outsiders. What would you recommend the social worker do next?

Encourage her to seek a friend from her own neighborhood to talk to	1 * 10%	19/
OR		
Encourage her to come in to counseling, reflecting to her that she may be too upset about the assault to keep it to herself, and that someone from her neighborhood may have difficulty understanding her feelings.	2 * 90%	

INTERVENTION WITH ASSAILANTS

INTERVENTION GOALS FOR ASSAILANTS

Instructions

Below is a list of generic intervention goals for assailants. For each goal listed, rate how important it is to intervention with assailants, using the 5-point scale shown below. Importance refers to the degree of priority you would give this goal. The higher the number, the higher your estimate of the goal's importance. The lower the number, the less important the goal. If you believe an item listed is not in fact a goal, please also rate it as "1."

1	2	3	4	5
Not Important or Not a Goal		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Goals	Importance					
To treat and rehabilitate self-and systems-identified assailants	1	2	3	4	5	20/
	* 0%	0%	4%	2%	94%	
To hold assailants legally accountable for their actions	1	2	3	4	5	21/
	* 0%	2%	0%	6%	92%	
To treat self-and systems-identified potential assailants	1	2	3	4	5	22/
	* 4%	0%	2%	25%	69%	

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 1

To treat and rehabilitate self- and systems- identified assailants

Instructions

Below is a list of desired outcomes that might be included under intervention with assailants. For each outcome, rate how important it is to meeting goal 1, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In deciding, please consider responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcome		Importance					
Assailant has personal insight into own internal emotional conflicts		1	2	3	4	5	29/
	*	2%	8%	32%	40%	18%	
Assailant has improved skills in how to manage life stress		1	2	3	4	5	30/
	*	0%	0%	6%	4%	90%	
Assailant uses alternative strategies to acting out sexuality aggressively		1	2	3	4	5	31/
	*	0%	0%	0%	6%	94%	
Assailant has a sense of self-worth		1	2	3	4	5	32/
	*	4%	2%	2%	40%	52%	
Assailant has improved skills in communicating with others		1	2	3	4	5	33/
	*	4%	0%	2%	56%	38%	
Assailant relates to women as human beings rather than as objects		1	2	3	4	5	34/
	*	0%	0%	2%	2%	96%	
Assailant has a support system that helps assailant from committing further assaults		1	2	3	4	5	35/
	*	0%	0%	2%	2%	96%	
Family and friends of assailant understand and cope with the assailant's actions		1	2	3	4	5	37/
	*	4%	0%	36%	54%	6%	

79-80/13

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 2

To hold assailants legally accountable for their actions

Instructions

Below is a list of desired outcomes that might be included under intervention with assailants. For each outcome, rate how important it is to meeting goal 2, using the 5-point scale as you did before.

1 — 2 — 3 — 4 — 5

1 Not Important or Not a Desired Outcome
3 Somewhat Important
5 Very Important

CARD 15 1-6/

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance					
		1	2	3	4	5	
As many assailants as possible are apprehended and convicted	*	4%	0%	0%	4%	92%	47/
The assailants who are apprehended and convicted are representative of the larger group of those who are actually committing the crime	*	4%	0%	4%	16%	76%	48/
Effective community action strategies bring a greater number of assailants into the criminal justice system	*	2%	2%	0%	6%	90%	49/
Assailants are effectively deterred from committing additional sexual assaults, reducing the repetition of such crimes	*	0%	0%	0%	0%	100%	50/
Assailants are held financially responsible for damages that have been incurred	*	4%	0%	0%	27%	69%	51/
Probationary requirements are well adhered to by assailants	*	0%	8%	0%	2%	90%	52/

79-80/14

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 3

To treat self- and systems- identified potential assailants

Instructions

Below is a list of desired outcomes that might be included under intervention with assailants. For each outcome, rate how important it is to meeting goal 3, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

CARD 15 1-6

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance					
The potential assailant uses constructive alternative strategies to coping with aggressive and sexual feelings		1	2	3	4	5	40/
	*	0%	0%	0%	0%	100%	
The potential assailant understands his own internal dynamics and emotional conflicts		1	2	3	4	5	41/
	*	0%	6%	33%	45%	16%	
All high-risk potential assailants identify themselves and seek help		1	2	3	4	5	42/
	*	2%	2%	6%	22%	68%	
The potential assailant relates to women as human beings rather than as objects		1	2	3	4	5	43/
	*	0%	2%	0%	4%	94%	
The potential assailant has support system of family and/or friends		1	2	3	4	5	44/
	*	2%	2%	2%	31%	63%	

79-80/15

KNOWLEDGE/SKILLS/SENSITIVITIES NEEDED BY SERVICE PROVIDERS

FOR INTERVENTION WITH ASSAILANTS

Instructions

Below is a list of knowledge, skills, and sensitivities that a service provider may need to function adequately in intervention with assailants. For each provider qualification listed, rate how important it is to intervention with assailants.

1	2	3	4	5
Not Important		Somewhat Important		Very Important

Indicate your response using the 5-point scale shown above. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

*last round responses (percentages)

CARD 16 1-6

Knowledge, Skills, Sensitivities	Importance					
	1	2	3	4	5	
Ability to use research and related information to most effectively apprehend and convict	*4%	6%	14%	12%	64%	31/
Ability to organize community support for programs aimed at apprehending and deterring assailants	*2%	2%	4%	16%	76%	36/
Ability to accurately identify potential assailants on the basis of clinical information	*8%	0%	10%	68%	14%	41/
Personal insight into one's own reactions/attitudes towards sexual assault	*0%	2%	8%	12%	78%	46/
Ability to understand and carry out activities in accordance with the legal and judiciary process	*0%	0%	6%	4%	90%	51/
Ability to effectively choose treatment or rehabilitation approach in accordance with the legal requirements and options	*0%	0%	6%	8%	86%	56/
Ability to apply knowledge of assailant psychological and sociological dynamics to treatment with individual assailants	*0%	4%	0%	0%	96%	61/
Ability to adjust treatment choice and approach according to the particular psychological problems assailant presents	*2%	0%	0%	4%	94%	66/
Ability to provide treatment which takes into account the cultural background of the assailant	*0%	2%	4%	69%	25%	71/
Ability to conduct interviews in a nonjudgmental manner	*2%	0%	4%	22%	72%	76/ 79-80/1 CARD 17 1-6/
Ability to conduct interviews in an ethical and responsible manner	*0%	0%	2%	0%	98%	7/
Ability to identify specific emotional reactions assailants may be experiencing	*0%	0%	0%	20%	80%	12/
Ability to use community resources effectively	*0%	0%	0%	16%	84%	17/
Ability to communicate knowledge regarding interpersonal aspects of human sexuality to assailants	*0%	2%	6%	71%	21%	22/
Ability to cope with one's own job-related stress and to find effective means of stress reduction	*0%	0%	2%	14%	84%	27/

*last round responses (percentages)

SPECIAL CONSIDERATIONS: ASSAILANTS

In the next section, we are interested in examining in greater detail special intervention issues involved in work with assailants. These issues highlight value differences in the field of sexual assault/abuse. So, while we expect a great variety of responses, we are very interested in the range and the extent of consensus in expert opinion.

1. What criteria should be used by service providers to assess the treatability of assailants? (i.e. the likelihood that any intervention strategy would have a positive effect on assailants). Use the following 5-point scale to show the relative importance of these criteria. Indicate your response by circling the appropriate number, after considering last round responses.

1	2	3	4	5
Not an Important Criteria		Somewhat Important Criteria		Very Important Criteria

Criteria		Importance					
Type of assault		1	2	3	4	5	46/
	*	4%	2%	12%	17%	65%	
Number of times assailant has sexually assaulted		1	2	3	4	5	47/
	*	2%	2%	2%	4%	90%	
Personality characteristics of the assailant		1	2	3	4	5	48/
	*	2%	0%	8%	23%	67%	
Assailant's motivation for the sexual assault/abuse		1	2	3	4	5	49/
	*	2%	2%	2%	12%	82%	
Amount of violence used by the assailant in the sexual assault/abuse		1	2	3	4	5	50/
	*	2%	0%	4%	10%	84%	
Type of victim selected to sexually assault/abuse		1	2	3	4	5	51/
	*	4%	0%	10%	61%	25%	

2. In your opinion how important are each of the motivations listed below? Use the following 5-point scale to make your ratings. Indicate how frequently you think each of the motivations listed below are the basis for assailants committing sexual assault. Indicate your response by circling the appropriate number, after considering last round responses.

1	2	3	4	5
Very Infrequent/ Not an Important Motive		Somewhat Frequent/ Somewhat Important Motive		Very Frequent/ Very Important Motive

		Importance					
Need to assert dominance over victim or group of which victim is a member		1	2	3	4	5	58/
	*	0%	0%	5%	4%	91%	

- Last round responses (percentages)

127

		Importance					
Need to assert assailant's sense of himself as a male		1	2	3	4	5	59/
	*	0%	2%	6%	39%	53%	
Need to express anger and/or rage toward victim or group of which victim is a member		1	2	3	4	5	60/
	*	0%	0%	4%	8%	88%	
Need to assert one's sexual virility		1	2	3	4	5	61/
	*	10%	23%	49%	14%	4%	
Need to express violence towards victim or group of which victim is a member		1	2	3	4	5	62/
	*	0%	4%	4%	35%	57%	
Desire for erotic arousal in suffering of victim		1	2	3	4	5	63/
	*	4%	45%	47%	2%	2%	
Desire for sexual satisfaction for assailants		1	2	3	4	5	64/
	*	39%	39%	20%	0%	2%	
Need to master personal inadequacies		1	2	3	4	5	65/
	*	2%	2%	39%	37%	20%	
Need to degrade/humiliate victim or group of which victim is a member		1	2	3	4	5	66/
	*	0%	2%	4%	18%	76%	

71-72/17

3. Do you think the same assailant generally commits different kinds of sexual assault on different occasions? Circle one, after considering last round responses.

	Yes$_1$	No$_2$	
			73/
*	18%	82%	

4. How frequently, in your view, are acts of sexual assault primarily sexual acts, primarily acts of violence, or both equally? Indicate your response by placing percentages in the spaces provided, so that the total represents 100% of sexual assault cases; in deciding, please consider last round responses.

last round responses:			
average = 13%; range = 0% - 70%	Sexual	____%	74-75/
average = 65%; range = 0% - 99%	Violent	____%	76-77/
average = 14%; range = 0% - 60%	Both equally	____%	78-79/
	Total	_100%	

*last round responses (percentages)

5. What are the main reasons that cause people to commit sexual assaults? Use the following 5-point scale to show the relative importance of these reasons. Indicate your response by circling the appropriate number, after considering last round responses.

1	2	3	4	5
Not an Important Reason		Somewhat Important Reason		Very Important Reason

CARD 18 1-6

		Importance					
Specific psychological conflicts that do not affect overall day-to-day functioning		1	2	3	4	5	7/
	*	8%	6%	59%	19%	8%	
Defects of personality structure		1	2	3	4	5	8/
	*	13%	15%	35%	31%	6%	
Genetic defect		1	2	3	4	5	9/
	*	96%	4%	0%	0%	0%	
Criminal orientation toward other people or society in general		1	2	3	4	5	10/
	*	2%	19%	69%	6%	4%	
Individual sexual disorder		1	2	3	4	5	11/
	*	44%	37%	13%	2%	4%	
Biochemical disorder		1	2	3	4	5	12/
	*	90%	8%	2%	0%	0%	
Extension of normal male sexuality		1	2	3	4	5	13/
	*	13%	4%	21%	10%	52%	
Socialization to the male role		1	2	3	4	5	14/
	*	4%	0%	10%	19%	67%	
Internalization of institutionalized sexism		1	2	3	4	5	15/
	*	4%	2%	12%	17%	65%	

*last round responses (percentages)

6. Do you think that the group of assailants currently being apprehended and convicted is representative of the larger group of those actually committing the crime? Circle Yes or No, after considering last round responses.

	Yes$_1$	No$_2$	
	* 8%	92%	45/

7. What changes should be employed to ensure that the group of assailants being apprehended and convicted is representative of the larger group of those actually committing the crime? Indicate your response to each item by circling Yes or No, after considering last round responses.

	Yes$_1$	No$_2$	
Court "watchdog" programs (monitoring court procedures)	* 81%	19%	46/
Research study of the relationship between rate of apprehension/conviction and population makeup in a community	85%	15%	47/
Community review boards to provide system of accountability of the legal system to the community	* 83%	17%	48/
Legal reform concerning definition of sexual assault	* 96%	4%	49/

8. What are the major obstacles in treatment of assailants? Use the following 5-point scale to indicate the importance of each obstacle. Indicate your response by circling the appropriate number, after considering last round responses.

	Importance					
	1	2	3	4	5	
Assailants low motivation to change	* 4%	2%	4%	9%	81%	60/
Social structure which supports coercive sexuality	* 0%	4%	13%	2%	81%	61/
Inadequate treatment methods for assailants	* 0%	0%	0%	6%	94%	62/
Inadequate knowledge concerning assailants	* 0%	0%	0%	33%	67%	63/
Difficulty interviewers have in working with assailants because of interviewers own feelings	* 2%	11%	75%	6%	6%	64/
Violent orientation of society	* 2%	2%	10%	17%	69%	65/

9. Do you think female service providers should be used in counseling of assailants? Circle Yes or No, after considering last round responses.

	Yes$_1$	No$_2$	
	* 94%	6%	72/
			79-80/18

*last round responses (percentages)

PRIMARY PREVENTION SECTION

The next part of this questionnaire is addressed to primary prevention. By "primary prevention" of sexual assault we mean only those activities that are directed at reducing or eliminating social conditions that increase the likelihood of sexual assault/abuse.

As before, we will begin by asking questions about the goals for primary prevention and more specific outcomes related to these goals. Then we will ask for your judgments about the relative effectiveness of different strategies for social change, and finally about the kinds of knowledge, skills, and sensitivities needed to implement them.

PRIMARY PREVENTION GOALS

Instructions

Below is a list of primary prevention goals for sexual assault. For each goal listed, rate how important it is to sexual assault prevention, using the 5-point scale as you did before.

1	2	3	4	5
Not Important or Not a Goal		Somewhat Important		Very Important

CARD 19 1-6,

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Goals		Importance					
To change structural features (policies and practices) of social institutions which support sexual assault/abuse		1	2	3	4	5	7/
	*	0%	0%	0%	10%	90%	
To change people's behavior in order to reduce the incidence of sexual assault/abuse for children and adults		1	2	3	4	5	8/
	*	2%	0%	0%	10%	88%	
To change people's attitudes/beliefs in order to reduce the incidence of sexual assault/abuse for children and adults		1	2	3	4	5	9/
	*	2%	0%	0%	8%	90%	

— *last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 1

To change structural features (policies and practices) of social institutions which support sexual assault/abuse

Instructions

Below is a list of desired outcomes that might be included under sexual assault primary prevention. For each outcome, rate how important it is to meeting goal 1, using the 5-point scale shown below.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes		Importance					
All workplaces ensure that women are not exploited or oppressed		1	2	3	4	5	16/
	*	0%	0%	4%	8%	88%	
All workplaces offer viable alternative models to existing hierarchical systems		1	2	3	4	5	17/
	*	6%	4%	61%	25%	4%	
All workplaces provide supportive structures (e.g. flexible time and child care arrangements)		1	2	3	4	5	18/
	*	6%	2%	23%	61%	8%	
All workplaces ensure an equitable distribution of women in positions of power and influence		1	2	3	4	5	19/
	*	2%	2%	10%	8%	78%	
Educational institutions provide curricula designed to decrease sex-role stereotyping		1	2	3	4	5	20/
	*	0%	0%	6%	2%	92%	
Educational institutions ensure availability of positive, non-sex-typed role models for children and youth		1	2	3	4	5	21/
	*	0%	0%	6%	2%	92%	
Advertising/media organizations ensure that women and men are portrayed as complete human beings		1	2	3	4	5	22/
	*	0%	4%	2%	0%	94%	
Advertising/media organizations communicate an attitude of intolerance toward violence in all programming		1	2	3	4	5	23/
	*	2%	0%	4%	2%	92%	
Religious institutions promote spiritual equality between women and men		1	2	3	4	5	24/
	*	4%	2%	17%	14%	63%	
Within family structure, parents raise their children in a manner that promotes development of each child's unique potential regardless of gender		1	2	3	4	5	25/
	*	0%	2%	0%	0%	98%	
Family organization ensures that children are not deprived, exploited or oppressed		1	2	3	4	5	26/
	*	0%	0%	0%	0%	100%	

*last round responses (percentages)

CARD 19

PREVENTION STRATEGIES FOR GOAL 1

To change structural features (policies and practices) of social institutions which support sexual assault/abuse

Instructions

Below is a list of strategies that might be included under sexual assault prevention. For each strategy listed, rate the effectiveness of each prevention strategy for promoting goal 1, using the 5-point scale shown below. The higher the number, the higher your estimate of the strategy's effectiveness. The lower the number, the less effective the strategy for promoting goal 1.

1	2	3	4	5
Not Effective		Somewhat Effective		Very Effective

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Prevention Strategies	Effectiveness					
Public pressure groups (e.g. letterwriting, sexual assault task forces, petitions)	1	2	3	4	5	33/
	* 0%	4%	25%	59%	12%	
Union organizing groups	1	2	3	4	5	34/
	* 4%	2%	23%	69%	2%	
Boycotting organizations and products	1	2	3	4	5	35/
	* 6%	4%	51%	21%	18%	
Political campaigning for candidates	1	2	3	4	5	36/
	* 4%	6%	59%	23%	8%	
Community accountability boards/advisory councils to business and government	1	2	3	4	5	37/
	* 4%	2%	45%	14%	35%	
Conferences focused on sexual assault prevention (local, state, national levels)	1	2	3	4	5	38/
	* 2%	2%	19%	67%	10%	
Consultation for curriculum development in schools	1	2	3	4	5	39/
	* 2%	6%	0%	53%	39%	
Inspection/monitoring programs of all workplaces	1	2	3	4	5	40/
	* 8%	2%	59%	29%	2%	
Increased recruitment efforts for women and on-the-job training	1	2	3	4	5	41/
	* 2%	0%	20%	37%	41%	
Education efforts for non-sexist, non-exploitive child rearing	1	2	3	4	5	42/
	* 0%	0%	0%	6%	94%	
Legislative lobbying groups	1	2	3	4	5	43/
	* 2%	2%	16%	4%	76%	

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 2

To change people's behavior in order to reduce the incidence
of sexual assault/abuse for children and adults

Instructions

Below is a list of desired outcomes that might be included under sexual assault primary prevention. For each outcome, rate how important it is to meeting goal 2, using the 5-point scale shown below.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision please consider the responses obtained from the previous round (printed just below the 5-point scale).

Desired Outcomes	Importance						
FEMALES							
Females are able to defend themselves physically and psychologically against violence and abuse		1	2	3	4	5	50/
	*	0%	0%	6%	14%	80%	
Females act assertively in interactions with other people		1	2	3	4	5	51/
	*	0%	2%	4%	10%	84%	
Females exhibit confidence in their own skills and abilities		1	2	3	4	5	52/
	*	0%	0%	4%	0%	96%	
Females exhibit self-reliant behavior and do not need to seek male approval		1	2	3	4	5	53/
	*	0%	0%	4%	12%	84%	
Female behavior is not dependent upon socially prescribed sex role norms		1	2	3	4	5	54/
	*	2%	0%	2%	4%	92%	
Females do not enage in coercive sexual behavior		1	2	3	4	5	55/
	*	4%	2%	8%	16%	70%	
MALES							
Males exhibit sensitivity to other people's feelings		1	2	3	4	5	56/
	*	0%	0%	2%	4%	94%	
Males do not use aggressive violent behavior against others		1	2	3	4	5	57/
	*	0%	0%	4%	4%	92%	
Male behavior is not dependent upon socially prescribed sex role norms		1	2	3	4	5	58/
	*	2%	0%	4%	6%	88%	
Males do not engage in any form of coercive sexual behavior		1	2	3	4	5	59/
	*	0%	0%	0%	2%	98%	
Males deal with anger toward others in constructive ways		1	2	3	4	5	60/
	*	0%	0%	0%	2%	98%	

*last round responses (percentages)

Desired Outcomes		Importance					
MALES							
Males exhibit cooperative behavior in interactions with others		1	2	3	4	5	61/
	*	2%	4%	8%	16%	70%	
Males respect females as equals		1	2	3	4	5	62/
	*	0%	2%	2%	0%	96%	

PREVENTION STRATEGIES FOR GOAL 2

To change people's behavior in order to reduce the incidence of
sexual assault/abuse for children and adults

Instructions

Below is a list of strategies that might be included under sexual assault prevention. For each strategy listed, rate the effectiveness of each prevention strategy for promoting goal 2, using the 5-point scale as you did for goal 1.

1	2	3	4	5
Not Effective		Somewhat Effective		Very Effective

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Prevention Strategies		Effectiveness					
Assertiveness training/classes for males and females		1	2	3	4	5	69/
	*	0%	0%	21%	65%	14%	
Consciousness-raising groups for males and for females		1	2	3	4	5	70/
	*	0%	2%	10%	25%	63%	
Male/female communication training		1	2	3	4	5	71/
	*	0%	2%	14%	55%	29%	
Self-defense classes for females		1	2	3	4	5	72/
	*	8%	8%	28%	30%	26%	
Feminist classes and training in non-sex-stereotyped areas		1	2	3	4	5	73/
	*	4%	8%	16%	59%	13%	
Sexual assault awareness programs		1	2	3	4	5	74/
	*	0%	2%	0%	20%	78%	
Parent education training		1	2	3	4	5	75/
	*	0%	2%	4%	8%	86%	
Non-sex-role-stereotyped curriculum development in schools		1	2	3	4	5	76/
	*	0%	0%	2%	8%	90%	
Sex role education training for teachers		1	2	3	4	5	77/
	*	0%	0%	2%	8%	90%	79-80/

*last round responses (percentages)

DESIRED OUTCOMES FOR GOAL 3

To change people's attitudes/beliefs in order to reduce the
incidence of sexual assault/abuse for children
and adults

Instructions

Below is a list of desired outcomes that might be included under sexual assault primary prevention. For each outcome, rate how important it is to meeting goal 3, using the 5-point scale shown below.

1	2	3	4	5
Not Important or Not a Desired Outcome		Somewhat Important		Very Important

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

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Desired Outcomes		Importance					
People believe in the value of human life		1	2	3	4	5	10/
	*	0%	6%	10%	0%	84%	
People believe in human equality and self-determination		1	2	3	4	5	11/
	*	0%	2%	0%	2%	96%	
People believe that unequal power relationships between males and females contribute to sexual assault and sexual oppression		1	2	3	4	5	12/
	*	2%	0%	4%	12%	82%	
People understand the sociocultural context of sexual assault/abuse		1	2	3	4	5	13/
	*	0%	0%	4%	12%	84%	
People have intolerance for any victimization of others		1	2	3	4	5	14/
	*	0%	0%	0%	2%	98%	
People believe that male/female interactions should be based on equality		1	2	3	4	5	15/
	*	0%	0%	4%	0%	96%	
People believe that certain features of institutional structures support unequal power relationships between males and females		1	2	3	4	5	16/
	*	0%	0%	10%	8%	82%	
People believe that particular personality characteristics and social roles should not be assumed to be linked with gender	*	1	2	3	4	5	17/
		2%	0%	8%	10%	80%	

*last round responses (percentages)

PREVENTION STRATEGIES FOR GOAL 3

To change people's attitudes/beliefs in order to reduce the incidence of sexual assault/abuse for children and adults

Instructions

Below is a list of strategies that might be included under sexual assault prevention. For each strategy listed, rate the effectiveness of each prevention strategy for promoting goal 3, using the 5-point scale as you did before.

1	2	3	4	5
Not Effective		Somewhat Effective		Very Effective

Indicate your response by circling the appropriate number. In making your decision, please consider the responses obtained from the previous round (printed just below the 5-point scale).

Prevention Strategies		Effectiveness					
Parent education training		1	2	3	4	5	24/
	*	0%	4%	0%	6%	90%	
Consciousness-raising groups for males and for females		1	2	3	4	5	25/
	*	0%	2%	10%	23%	65%	
Non-sex-role-stereotyped curriculum development in schools		1	2	3	4	5	26/
	*	0%	0%	6%	6%	88%	
Sex role education training for teachers		1	2	3	4	5	27/
	*	0%	0%	6%	8%	86%	
Media campaigns		1	2	3	4	5	28/
	*	0%	2%	8%	29%	61%	
Sexual assault awareness programs		1	2	3	4	5	29/
	*	0%	0%	4%	28%	68%	
Feminist classes and training in non-sex-stereotyped areas		1	2	3	4	5	30/
	*	6%	4%	14%	52%	24%	

*last round responses (percentages)

KNOWLEDGE/SKILLS/SENSITIVITIES NEEDED BY PRIMARY PREVENTERS

FOR SEXUAL ASSAULT PREVENTION

Instructions

Below is a list of knowledge, skills, and sensitivities that a service provider may need to function adequately in sexual assault prevention. For each provider qualification listed, rate how important it is to primary prevention.

1	2	3	4	5
Not Important		Somewhat Important		Very Important

Indicate your answer using the 5-point scale shown below. Please consider last round responses in making your decision.

Knowledge/Skills/Sensitivities		Importance					
		1	2	3	4	5	
Ability to apply learning principles to prevention efforts	*	0%	0%	2%	36%	62%	37/
Ability to communicate ideas clearly and persuasively	*	0%	0%	0%	4%	96%	42/
Ability to use community resources effectively	*	0%	0%	0%	4%	96%	47/
Ability to apply knowledge of socio-cultural dynamics of sexual assault to prevention	*	0%	0%	0%	12%	88%	52/
Ability to apply knowledge of inequities in power relationships between males and females to prevention	*	0%	0%	4%	22%	74%	57/
Ability to mobilize diverse groups of people	*	0%	0%	4%	6%	90%	62/
Ability to apply knowledge of relationship between socialization practices and sexual assault	*	0%	0%	2%	8%	90%	67/
Mastery of group process skills	*	0%	0%	6%	68%	26%	72/ 79-80/20 CARD 21 1-6
Sensitivity to alternative values/ orientation of different social systems and groups of people	*	0%	0%	0%	14%	86%	7/
Personal insight into own attitudes/ reactions to sexual assault	*	0%	0%	6%	20%	74%	12/

*last round responses (percentages)

SPECIAL CONSIDERATIONS: Primary Prevention

1. What are the fundamental causes for sexual assault? Use the following 5-point scale to show the importance of the suggested causes. Indicate your response by circling the appropriate number, after considering last round responses.

1	2	3	4	5
Not an Important Cause		Somewhat Important Cause		Very Important Cause

		Importance					
Natural sexual instincts		1	2	3	4	5	31/
	*	82%	14%	4%	0%	0%	
Biological aggressive drives		1	2	3	4	5	32/
	*	76%	18%	4%	2%	0%	
Economic structure supporting female dependence on males		1	2	3	4	5	33/
	*	4%	6%	16%	54%	20%	
High prevalence of violence in society		1	2	3	4	5	34/
	*	0%	0%	4%	12%	84%	
Social structure which promotes power discrepancies between males and females		1	2	3	4	5	35/
	*	0%	6%	4%	10%	80%	
Social conventions perpetuating sexism		1	2	3	4	5	36/
	*	0%	6%	0%	14%	80%	
Social conventions perpetuating racism		1	2	3	4	5	37/
	*	6%	14%	46%	26%	8%	
Breakdown of nuclear family structure		1	2	3	4	5	38/
	*	76%	8%	12%	2%	2%	
Blurring of roles between male and female		1	2	3	4	5	39/
	*	88%	10%	2%	0%	0%	
Female's changing social role from domestic sphere to public sphere		1	2	3	4	5	40/
	*	72%	16%	12%	0%	0%	
Female style as enticing		1	2	3	4	5	41/
	*	88%	10%	0%	2%	0%	

*last round responses (percentages)

2. What proportion of the overall sexual assault effort should be allocated to each of the following areas? Indicate your response by placing percentages in the spaces provided, so that the total represents 100% of sexual assault effort. In deciding, please consider last round responses.

last round responses			
average = 31%; range = 0%-60%	Primary prevention	___ %	48-49/
average = 20%; range = 0%-50%	Treatment of adult victims	___ %	50-51/
average = 20%; range = 0%-30%	Treatment of juvenile victims	___ %	52-53/
average = 14%; range = 0%-60%	Treatment of assailants	___ %	54-55/
average = 14%; range = 0%-50%	Holding assailants legally accountable	___ %	56-57/
	Total:	100 %	

3. Which of the following institutions should be targeted first for primary prevention of sexual assault? Select 2 institutions that you think should be targeted first and place a 1 next to each of them; leave the rest blank. In deciding, please consider last round responses.

Families	___	[†] 41%	58/
Business	___	[†] 0%	59/
Government	___	[†] 0%	60/
Religion	___	[†] 0%	61/
Military	___	[†] 0%	62/
Education	___	[†] 47%	63/
Mental Health	___	[†] 1%	64/
Health Care/ Medical	___	[†] 0%	65/
Advertising/ Media	___	[†] 10%	66/
Criminal Justice	___	[†] 0%	67/
Politics	___	[†] 0%	68/
Athletics	___	[†] 0%	69/
Social Welfare	___	[†] 1%	70/

73-74/2

[†] percentage of last round respondents who indicated this institution as a first target for primary prevention.

4. Based on your general principles of prevention, with whom should primary prevention efforts for sexual assault start first? Select 2 groups that you think should be targeted for primary prevention efforts first and place a 1 next to each of them; leave the rest blank. In deciding, please consider last round responses.

Young children (ages 0-5)	___	[t] 3%	75/
Elementary age children	___	[t] 18%	76/
Early adolescents (ages 11-13)	___	[t] 37%	77/
Adolescents	___	[t] 7%	78/
Adult women	___	[t] 3%	79/
Adult men	___	[t] 1%	80/
			CARD 22 1-6
General public	___	[t] 31%	7/
Elderly people	___	[t] 0%	8/
Non Caucasian people	___	[t] 0%	9/

[t] percentages of last round respondents who indicated this group as a first target for primary prevention.

5. Do you consider any of the following segments of the population at high risk (particularly vulnerable) for being sexually assaulted/abused? Indicate your response by circling Yes or No, after considering last round responses.

Young children (ages 0-5)	Yes$_1$ * 82%	No$_2$ 18%	14/
Elementary age children	Yes$_1$ * 90%	No$_2$ 10%	15/
Early adolescents (ages 11-13)	Yes$_1$ *100%	No$_2$ 0%	16/
Adolescents	Yes$_1$ *100%	No$_2$ 0%	17/
Adult women	Yes$_1$ * 96%	No$_2$ 4%	18/
Adult men	Yes$_1$ * 12%	No$_2$ 88%	19/
Elderly people	Yes$_1$ * 74%	No$_2$ 26%	20/
Disabled people	Yes$_1$ * 82%	No$_2$ 18%	21/
Non Caucasian groups	Yes$_1$ * 80%	No$_2$ 20%	22/
Lower socioeconomic groups	Yes$_1$ * 86%	No$_2$ 14%	23/
Middle class groups	Yes$_1$ * 27%	No$_2$ 73%	24/

*last round responses (percentages)

6. Should members of the public undertake action strategies, that are within the law, to hold assailants accountable to the community for their actions? (e.g. publicizing names of assailants). Consider last round responses in answering.

Circle one: Yes$_1$ No$_2$ 29/

* 92% 8%

7. Which of the following prevention strategies do you recommend individuals use to minimize the risk of sexual assault? Circle one number only, indicating the strategy you would recommend. Consider last round responses in answering.

Individual action (e.g. self-defense training) 1 * 6%

OR 30/

Collective action (e.g. tenant organizing) 2 * 94%

8. In a community education program dealing with sexual assault prevention, which one of the following strategies do you recommend be used by the presenter to deal with the issue of susceptibility to sexual assault/abuse? Circle one number only, indicating the strategy you would recommend. Consider last round responses in answering.

Raise the audience members' anxiety about their susceptibility by telling them that sexual assault can and does happen to anyone, anytime, anywhere 1 * 88%

OR 31/

Lower the audience members' anxiety by stressing that if they take certain precautions they probably won't be sexually assaulted 2 * 12%

9. In a community education program dealing with sexual assault prevention, which one of the following strategies do you recommend be used by the presenter to deal with the issue of severity of sexual assault/abuse? Circle one number only, indicating the strategy you would recommend. Consider last round responses in answering.

Stress how sexual assault is a devastating, traumatic life-threatening experience which leaves long-term scars on those victimized 1 * 0%

OR 32/

Emphasize how sexual assault is an emotionally traumatic experience which can have serious consequences but from which victims do recover and may even be emotionally stronger as a result 2 * 100%

10. Do you think individuals or institutional systems can be motivated to change their attitudes or behaviors toward sexual assault if they are not reacting to a stressful situation? Consider last round responses in answering.

Circle one: Yes$_1$ No$_2$ 33/

* 90% 10%

*last round responses (percentages)

CONCEPTS/DEFINITIONS SECTION

Throughout the questionnaire we have been assuming a more-or-less common usage of intervention and prevention concepts and the labels used to refer to them. Now we would like to make these meanings explicit. In this section, then, we want your judgment about how to formulate appropriate definitions and labels for concepts related to sexual assault.

Specifically, we are asking you to indicate the labels you think should be applied to specific sexual assault concepts and to indicate the descriptions that you think ought to form the basis for defining these concepts.

LABEL CHOICES

Instructions

Each concept described below is followed by a list of possible labels, or terms, that may be used to refer to it. Please examine the terms carefully:

> Circle YES for the VERY BEST term, the term you think ought to be used by providers;
> Circle NO for any terms that definitely SHOULD NOT BE USED by providers; leave the rest blank.
>
> In responding, please consider feedback from the previous round printed below the choices.

1. An act in which someone has been forced to engage in some kind of sexual activity:

sexual exploitation		Yes$_1$	No$_2$	38/
	[t]	38%	61%	
rape		Yes$_1$	No$_2$	39/
	[t]	45%	54%	
victimization		Yes$_1$	No$_2$	40/
	[t]	25%	75%	
sexual assault		Yes$_1$	No$_2$	41/
	[t]	98%	2%	
sexual coercion		Yes$_1$	No$_2$	42/
	[t]	87%	12%	
molestation		Yes$_1$	No$_2$	43/
	[t]	7%	93%	
sexual violation		Yes$_1$	No$_2$	44/
	[t]	18%	82%	
sexual abuse		Yes$_1$	No$_2$	45/
	[t]	82%	18%	

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[t] percentage of last round respondents who were definitely positive or definitely negative about providers' use of this label.

II. A person who forces another to engage in some kind of sexual activity:

perpetrator	Yes$_1$ [t] 14%	No$_2$ 86%	50/
victimiser	Yes$_1$ [t] 8%	No$_2$ 92%	51/
offender	Yes$_1$ [t] 67%	No$_2$ 33%	52/
sexual abuser	Yes$_1$ [t] 50%	No$_2$ 50%	53/
sexual exploiter	Yes$_1$ [t] 12%	No$_2$ 87%	54/
assailant	Yes$_1$ [t] 98%	No$_2$ 2%	55/
coercer	Yes$_1$ [t] 7%	No$_2$ 93%	56/
assaulter	Yes$_1$ [t] 40%	No$_2$ 60%	57/
rapist	Yes$_1$ [t] 73%	No$_2$ 27%	58/
molester	Yes$_1$ [t] 5%	No$_2$ 95%	59/
sex offender	Yes$_1$ [t] 79%	No$_2$ 21%	60/
violator	Yes$_1$ [t] 3%	No$_2$ 97%	61/
abuser	Yes$_1$ [t] 23%	No$_2$ 77%	62/

[t] percentage of last round respondents who were definitely positive or defintely negative about providers' use of this term.

III. Term to refer to person who has been forced to engage in some kind of sexual activity:

victim	Yes$_1$ [t] 94%	No$_2$ 6%	67/
survivor	Yes$_1$ [t] 21%	No$_2$ 79%	68/

71-72/22

[t] percentage of last round respondents who were definitely positive or definitely negative about providers' use of this term.

IV. Term to refer to the entire group of Asian/Pacific, Black, Hispanic, Native American, and Arab people:

Ethnic minorities	Yes$_1$	No$_2$	73/
	* 93%	7%	
Non-Caucasian people	Yes$_1$	No$_2$	74/
	* 3%	97%	
Racial minorities	Yes$_1$	No$_2$	75/
	* 36%	64%	
Third World persons	Yes$_1$	No$_2$	76/
	* 12%	87%	
People of color	Yes$_1$	No$_2$	77/
	* 16%	84%	
Special populations	Yes$_1$	No$_2$	78/
	* 6%	94%	
Non-Whites	Yes$_1$	No$_2$	79/
	* 3%	97%	
Minorities	Yes$_1$	No$_2$	80/
	* 40%	60%	CARD 23 1-6

*percentage of last round respondents who were definitely positive or definitely negative about providers' use of this term.

DEFINITIONS OF CONCEPTS

Instructions

Below are some statements that have been used as the basis for defining two important concepts, sexual assault and incest. For each concept, consider the definitions and place a 1 by the single definition you think is BEST: place a 2 next to any others you think are also good definitions; leave the rest blank.

Then rate all of the definitions according to how practical it is for providers to use as a day-to-day operating definition. There may be cases where you agree that a statement is good as a definition and yet think it is impractical to use for guiding program decisions, or vice versa. Use the following 5-point scale to make your ratings. The higher the number, the higher your estimate of the statement's practicality. Lower numbers indicate less practical values.

1	2	3	4	5
Not Practical		Somewhat Practical		Very Practical

Indicate your response by circling the appropriate number. In deciding, please consider feedback about previous round responses.

Definitions of SEXUAL ASSAULT		Quality	Practicality					
Any forced sexual activity	** 80%	____	1	2	3	4	5	11-12/
			* 2%	0%	0%	2%	96%	
A violent act in which a person or group forces another person under threat of physical or emotional harm or deception to engage in sexual activity	** 2%	____	1	2	3	4	5	13-14/
			* 2%	4%	32%	19%	43%	
A male's penetrating with his penis a female's vagina against the female's will	** 0%	____	1	2	3	4	5	15-16/
			* 85%	7%	4%	0%	4%	

*last round responses (percentages)
**percent of last round respondents who chose this as the best definition

Definitions of SEXUAL ASSAULT		Quality		Practicality					
Any sexual intimacy forced on one person by another	** 2%	____		1	2	3	4	5	17-18/
			*	4%	18%	48%	21%	9%	
Attempted or actual forced sexual activity, ranging from surprise attacks with threat of physical harm to social encounters where sexual contact is unexpected or not agreed upon	** 15%	____		1	2	3	4	5	19-20/
			*	4%	7%	20%	54%	15%	

Definitions of INCEST		Quality		Practicality					
Sexual activity brought about by coercing, manipulating, or deceiving a relative or dependent, other than a spouse	** 86%	____		1	2	3	4	5	29-30/
			*	2%	0%	6%	11%	81%	
Sexual victimization of a child by a blood relative	** 0%	____		1	2	3	4	5	31-32/
			*	29%	11%	39%	14%	7%	
Intercourse or any attempt to commit intercourse between the following persons: parents and children, ancestors and descendants of every degree, brothers and sisters by marriage or blood, uncles and nieces or aunts and nephews	** 2%	____		1	2	3	4	5	33-34/
			*	47%	7%	38%	4%	4%	
A parent or sibling of a child or one who is in that role forcing the child to engage in sexual activity	** 9%	____		1	2	3	4	5	35-36/
			*	2%	2%	14%	61%	21%	
A family member sexually stimulating a child in ways which are inappropriate for the child's age and level of development	** 2%	____		1	2	3	4	5	37-38/
			*	48%	20%	15%	15%	2%	

*last round responses (percentages)
**percent of last round respondents who chose this as the best definition

CARD 23

BUILDING AN EXPLANATORY STRUCTURE FOR SEXUAL ASSAULT AND INCEST

There is substantial agreement in the field that in explaining the nature of sexual assault or incest, it is appropriate to take into account three dimensions: (1) the relationship between assailant and victim, (2) the range of sexual activity involved, and (3) the degree of coercion. However, there is considerable disagreement about just where on each of these dimensions it is proper to draw the line in interpreting the concept.

For each concept, we have listed the three dimensions. There are a series of headings under each dimension that mark off theoretical places for drawing the line or limiting the concept's interpretation. The headings range along a continuum from narrow and strict to broad and liberal interpretations. Please consider which of the headings below each dimension, in your view, is the best place to bound the interpretation of the concept. Place an X next to your choice in this continuum. We are assuming that any heading implicitly includes all the others above it. In making your decision, please consider feedback about previous round responses.

SEXUAL ASSAULT

I. Relationship to victim

stranger	___	1 t	2%	
acquaintance	___	2 t	0%	
friend	___	3 t	0%	47/
lover	___	4 t	0%	
relative by blood, marriage or adoption	___	5 t	98%	

II. Range of sexual activity between the assailant and the victim

vaginal intercourse	___	1 t	0%	
anal intercourse	___	2 t	0%	
oral-genital contact	___	3 t	0%	
masturbation	___	4 t	0%	48/
genital fondling	___	5 t	12%	
display of genitals in a sexual context without contact	___	6 t	69%	
overtly expressed sexual interest on a verbal level	___	7 t	19%	

*last round responses (percentages)

(continued)

SEXUAL ASSAULT

III. Degree of coercion

inability to consent	____	1[t]	0%	
physical harm/injury	____	2[t]	0%	
a threat of death	____	3[t]	0%	
a threat of physical harm or injury	____	4[t]	2%	49/
deception or fraud	____	5[t]	0%	
a threat of significant emotional loss or harm	____	6[t]	2%	
a threat of significant tangible loss	____	7[t]	4%	
implied threat (non-verbalized, but perceived)	____	8[t]	55%	
promised emotional or tangible rewards	____	9[t]	37%	

INCEST

I. Relationship to victim

parent or sibling	____	1[t]	0%
any blood relative	____	2[t]	0%
any relative by blood or marriage	____	3[t]	0%
any relative by blood, marriage, or adoption	____	4[t]	2%
any relative by blood, marriage, adoption, or any person in the parent or guardian role	____	5[t]	98%

[t] last round responses (percentages)

(continued)

II. Range of sexual activity between the assailant and the victim

vaginal intercourse	____	1	[t] 0%	
anal intercourse	____	2	[t] 0%	
oral-genital contact	____	3	[t] 0%	
masturbation	____	4	[t] 0%	51/
genital fondling	____	5	[t] 8%	
display of genitals in a sexual context without contact	____	6	[t] 12%	
overtly expressed sexual interest on a verbal level	____	7	[t] 80%	

III. Degree of coercion

inability to consent	____	1	[t] 0%	
physical harm/injury	____	2	[t] 0%	
a threat of death	____	3	[t] 0%	
a threat of physical harm or injury	____	4	[t] 0%	
deception or fraud	____	5	[t] 0%	52/
a threat of significant emotional loss or harm	____	6	[t] 2%	
a threat of significant tangible loss	____	7	[t] 0%	
implied threat (non-verbalized, but perceived	____	8	[t] 2%	
promised emotional or tangible rewards	____	9	[t] 96%	

79-80/23

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[t] last round responses (percentages)

APPENDIX B: METHODS FOR ACHIEVING AIMS AND ACQUIRING SKILLS

The purpose of this Appendix is to present preliminary data about methods for achieving aims and acquiring skills which were obtained from the first round questionnaire. As we explained in the Procedures Chapter, these items were eliminated from subsequent rounds due to concern for length and time. However, initial responses are of interest in suggesting concrete means for actualizing many of the recommendations discussed in the Results Chapter.

For convenience, data related to intervention programs and services are presented in the same way for victim intervention and assailant intervention, respectively. First, each intervention goal is given, followed by a list of possible programs and services suitable for promoting it. We have tallied the number of times a program or service was designated by respondents as useful in attaining outcomes related to that goal. These numbers appear at the left in the list. It should be noted that since different goals were associated with differing numbers of outcomes, the maximum number of possible endorsements differs from list to list. Therefore, to assist in evaluating the significance of the actual numbers of times a program or service was designated, maxima are given following each goal statement.

Methods for acquiring knowledge, skills, and sensitivities have been treated similarly. That is, responses to inquiries about how providers could attain needed skills were tallied for victim intervention, assailant intervention, and primary prevention. These data have been tabled at the end of this Appendix.

PROGRAMS/SERVICES FOR VICTIM INTERVENTION

GOAL 1: To minimize the risk to potential victims of being sexually assaulted/abused (max=3660)

376 - High-risk-victim identification programs
149 - Self-defense programs
99 - Assertivness training
145 - Consciousness-raising activities
182 - Neighborhood watch programs
84 - Home inspection programs
520 - Sexual assault awareness programs
303 - Parent education programs
334 - Public education individual prevention strategies
458 - Public education of nature, scope and severity of sexual assault
155 - Consultation programs to city planners, architects, etc.

GOAL 2: To identify sexually assaulted/abused individuals (max=2196)

126 - Early detection programs
73 - Emergency intervention sexual assault teams
174 - Outreach campaigns of available sexual assault services
126 - Sexual assault identification training
105 - Parent education programs
90 - Sexual assault awareness training
104 - Public education about how to identify possible sexual assault/abuse victims
65 - Public education about nature, scope, and severity of sexual assault

GOAL 3: To assist victims in coping with the emotional impact of the sexual assault/abuse (max=4392)

538 - Crisis intervention
101 - 24-hour crisis hotline services
319 - Individual therapy
159 - Family therapy
52 - Group therapy
74 - Play therapy groups
90 - Self-help groups
125 - Protective services for assaulted/abused children
4 - Foster care programs
5 - Residential treatment programs
2 - Psychiatric hospitalization
23 - Assertiveness training
19 - Sex education programs
103 - Sexual assault awareness training
68 - Information and referral services
43 - Advocate to negotiate various systems

GOAL 4: To assist victims in coping with the physical trauma associated with the sexual assault/abuse (max=2928)

429 - Emergency sexual assault medical intervention teams
189 - Crisis intervention for victims concerning their physical condition
85 - Medical follow-up services
198 - Advocate to negotiate medical system
77 - Medical orientation services to examination procedures
69 - Medical information services
36 - Information and referral services
49 - Sexual assault awareness training

GOAL 5: To assist victims in coping with the criminal justice procedures (max=2562)

469 - Specially trained sexual assault investigation units
38 - Specially trained sexual assault prosecution units
84 - Criminal justice orientation programs
27 - Information and referral services
255 - Advocate to negotiate criminal justice system
79 - Protective services for sexually assaulted/abused children
39 - Victim/witness programs

GOAL 6: To assist the families and friends of victims in coping with emotional stress associated with the sexual assault/abuse (max=2196)

235 - Crisis intervention
105 - Family therapy
91 - Joint therapy for victim's parents
43 - Self-help groups
37 - Parenting skill training
25 - Stress management programs
93 - Information and referral services
145 - Community programs to assist family and friends through various services
64 - Sexual assault awareness training

GOAL 7: To assist incest families in coping with the emotional stress associated with the sexual assault/abuse (max=3294)

180 - Crisis intervention
539 - Family therapy
84 - Self-help groups
16 - Social skill training for parents
53 - Parenting skill training
8 - Residential treatment for incest families
91 - Collaboration treatment between mental health and the criminal justice systems
13 - Stress management programs
59 - Sex role re-socialization training
95 - Incest awareness education training
34 - Information and referral services
56 - Community programs to assist incest families through various services

PROGRAMS/SERVICES FOR ASSAILANT INTERVENTION

GOAL 1: To treat and rehabilitate self-and systems-identified assailants (max=2196)

23 - Crisis intervention
46 - 24-hour crisis hotlines
211 - Individual therapy
185 - Group therapy
240 - Self-help groups
160 - Family therapy
0 - Psychiatric hospitalization
2 - Medication/chemotherapy
119 - Behavior modification programs
49 - Sexual dysfunction treatment
222 - Social skill training
168 - Sex role re-socialization training
93 - Stress management programs
71 - Advocacy programs for assailants

GOAL 2: To hold assailants legally accountable for their actions (max=1464)

55 - Incarceration
41 - Probation
90 - Social rehabilitation programs
34 - Work-furlough
44 - Community-based halfway house services
10 - Psychiatric hospitalization
2 - Chemotherapy/Medication
136 - Specialized sexual assault investigation units
208 - Specialized sexual assault prosecution units
114 - Specialized sexual assault probation units
79 - Court monitoring programs
191 - Community-based law enforcement auxillary programs
35 - Technical assistance programs to improve prosecution evidence
107 - Public education of sexual assault
62 - Data gathering on assailant characteristics
2- Psychosurgery

GOAL 3: To treat self-and systems-identified potential assailants (max=1464)

14 - Crisis intervention
68 - 24 hour crisis hotline services
133 - Individual therapy
119 - Group therapy
119 - Self-help groups
73 - Family therapy
14 - Diversion programs
5 - Recreational programs
2 - Vocational training programs
89 - Behavior modification programs
59 - Stress management programs
132 - Sex role re-socialization programs
0 - Chemotherapy/medications
8 - Residential treatment
0 - Psychiatric hospitalization
30 - Information and referral services
87 - Early detection service for assaultive behavior
89 - Community education of characteristics of high-risk potential assailants

METHODS FOR ACQUIRING PROVIDER SKILLS

Methods	Victim Intervention (max=2928)	Assailant Intervention (max=2074)	Primary Prevention (max=976)
Formal education or professional	283	191	192
Continuing education	138	106	106
Inservice education/training	480	302	307
Supervision	180	163	172
Case/program consultation	146	98	112
Apprenticeship	177	70	70
Independent reading & research	146	39	37
Work experience	255	123	153
Life experience	74	71	56
Personal therapy	54	28	38
Consciousness-raising groups	62	37	52

The results of these preliminary data about methods for achieving aims and acquiring skills are described below. With regard to programs and services for achieving each of the seven victim intervention goals, the following picture emerged. For Goal 1--to minimize the risk to potential victims--sexual assault awareness programs, public education (of nature, scope and severity of sexual assault), and high risk victim identification programs were most frequently checked. For Goal 2-- to identify sexually assaulted/abused individuals--outreach campaigns of available sexual assault services, early detection programs, and sexual assault identification training were most frequent. For Goal 3--to assist victims in coping with the emotional impact--crisis intervention and individual therapy were checked most frequently. In contrast, foster care programs, residential treatment programs, and psychiatric hospitalization received very few endorsements. For Goal 4--to assist victims in coping with the physical trauma--emergency sexual assault medical intervention teams, advocate to negotiate medical system, and crisis intervention for victims concerning their physical condition received strongest endorsement. For Goal 5--to assist victims in coping with the criminal justice procedure--participants most frequently checked specially trained sexual assault investigation units, and advocate to negotiate criminal justice system. For Goal 6--to assist the families and friends of victims--crisis intervention, community programs to assist family and friends through various services, and family therapy, were most frequently checked. Finally, for Goal 7--to assist incest families in coping with the emotional impact--crisis intervention and community programs were most frequently endorsed.

With regard to methods for achieving the three assailant intervention goals, respondents endorsed the following programs/services. For Goal 1--to treat and rehabilitate assailants self-help groups, social skill training, individual therapy and sex role re-socialization training were most frequently checked. Psychiatric hospitalization, psychosurgery, medication/chemotherapy, in contrast, received little or no endorsement. For Goal 2--to hold assailants legally accountable--specialized sexual assault prosecution units and community-based law enforcement auxillary programs were most strongly endorsed. Chemotherapy/medication and psychiatric hospitalization received little endorsement. For Goal 3--to treat potential assailants--individual therapy and sex role re-socialization programs were most frequently checked. Programs receiving little or no endorsement included chemotherapy/medication, psychiatric hospitalization, vocational training programs, recreational programs and residential treatment.

Respondents most frequently endorsed four methods for acquiring provider skills for victim intervention, assailant intervention, and primary prevention: inservice education/training, formal education or professional school, work experience, and supervision.